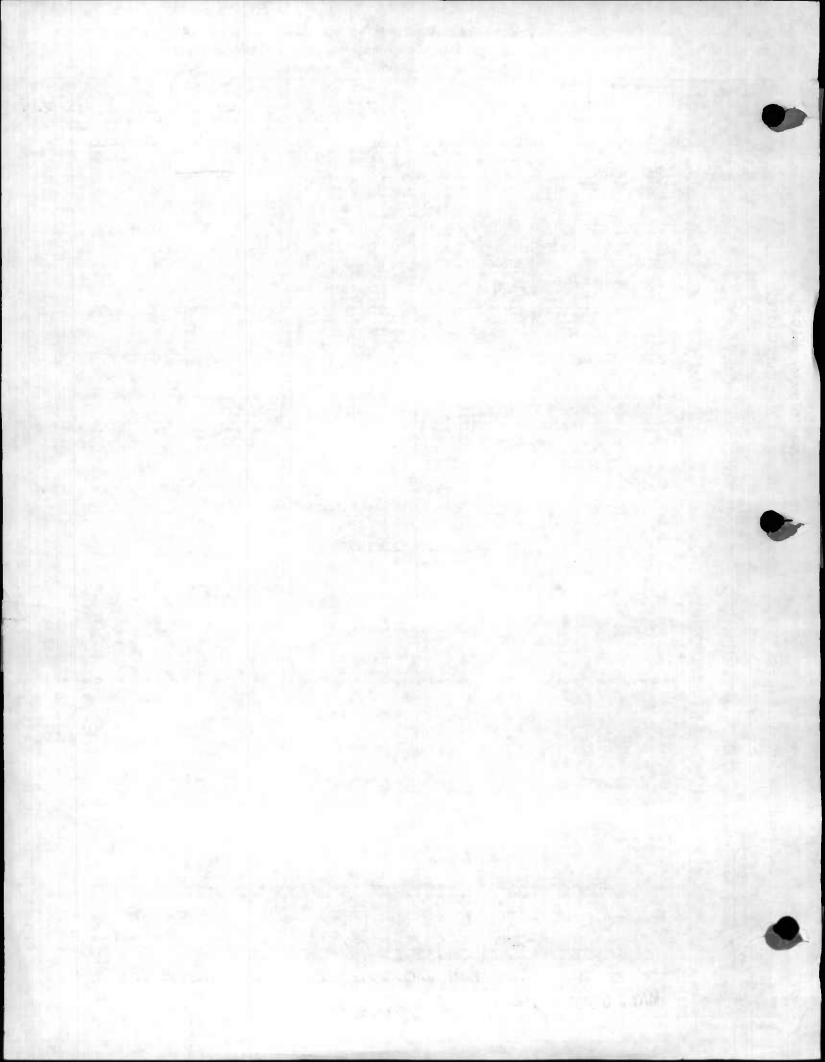
State of Maryland / Department of Health and Mental Hygiene AMEND#8 PER F.H. G783 5-30-2000 JAB Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Dev **Physician** POLOVOY 8:55 P.M. May 24 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD MD 21052 VA MEDICAL CENTER, FORT HONGE 24 Hrs. 8. Data of Birth 1 -6. (Month, Day, Year) BALTIMORE 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 130 M 20 F Director 213-09-8828 88 11-6-RUSSIA Usual Rasidance of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show edical Examiner must be notified at MD BALTIMORE 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ក់ 117 NELSON ROAD 21208 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Raca - Amarican Indian, Black, White, atc 1 Yas 2 □ No If Yas, Giva Year or Dates: 1 Navar Marriad 2 Married WWII Maryland 21215-0020 1 Yes 2 No Specify: WHITE þ Specify 3 Widowed 4 □ Divorced Polowoy, Milton Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry the Me filled within Elamantary/Secondary (0-12) Collega (1-4or 5+) PRINTER PRINTING 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Mental h JACOB POLOVOY LIBBY PORTNOI 0 Pages 1 and 2 should 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) LINDA POLOVOY / DAUGHTER 117 NELSON ROAD - BALTIMORE, MD 21208 altimore, 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 M Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata MOGAN ABRAHAM CEMETERY 5/26/00 ROSEDALE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licensea 22. Name and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Batween Onsat and Daeth Physician /Medical Immediata Causa (Finel A HEPATOCELLULAR CARCINOMA diseesa or condition rasulting in death) **Examiner** Due to (or as a consequence of) Examiner that the deeth certificata be axecuted physician and s the burial-trans Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Couse (Disaase or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Dua to (or es a consequenca of) for use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings eveilabla prior to completion of causa of death? 24a. Was an autopsy performed? Completed hes paga 2 1 Yes 20 No 1 ☐ Yas 2 ☐ No cartificate Division of Vital director, 25. Was casa refarred to medical axaminar? Be 26. Placa of Daath (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 2 1 Yas 2 No 1 ☑ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury et Work? Certification: 28d. Describe how injury occurred Aftar Attending 1 DNaturel 5 Pending investigation after death. Diractor: Af 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of tnjury - At homa, farm, streat, factory, offica building, atc. (Specify) filled in by 4 Homicide 6 24 hours a Hospital 29a. Cartifier 1 Certifying Physician: To tha bast of my knowledge, deeth occurred et tha time, data and plece, end due to the cause(s) and mennar es stated Medical pletaly 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, deta and place, and due to the ceuse(s) and manner stated. (Check only one) To the To the F 29b. Signatura and titla, a burti 29c. Licansa number 29d. Data signad (Month, Day, Year) 05/24/2000 047804 ome 30. Name and poores of person who complated causa of daath (Itam 23a) (Type, Print) ANDREW MROWIEC, M.D., VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052 31. Date filed (Month, Day, Year) MAY 3 0 2000 32. Ragistrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Lucille Ramsey 4b. City, Town, or Location of Death 2000 27, 1:20am /Medical 4a Fecility Name (# not institution, give street and number) 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) 05-26-33 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Days 10 M 20 F Months Hours 67 Yrs. NC 213-52-7299 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits a or 28a-f show ty Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "netural", or items 23s USA 4408 Wrenwood Avenue 21212 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. lid be filed within 72 hours efter de entel Hygiene. ked other than "natural", or flem is event, the Maid cal Examinal Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3K Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Company llth Grade permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If Item 27 is marked other any Injury or other traumatic event, potes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Della Shepard Riddick Mack 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21212 19a. Informant's Name/Relationship (Type, Print) 4408 Wrenwood Avenue Baltimore, Maryland Carolyn Ramsey 20a. Method of Disposition
TE Burial 2 Cremetion 3 Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata Western Star Cemetery 06-01-2000 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee 8 mony MUMMIN WM.C.March FH 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physicien and s the burial-trensit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Box 68760. Physician/Medical Due to (or as a consequenca of): Part it. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 1 Unknown signed b Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Dete of injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division Hospital or Attending | 24 hours after death. 1 Netural 5 Pending investigation ours after death. neral Director: Aft filled in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours at To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Cartifier 29d. Dete signed (Month, Day, Year) 5/30/2000 29c. License number 29b. Signature and title of ceglifier na Street Baltimore MD 21201 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) AHMED 821 N- Eutaw

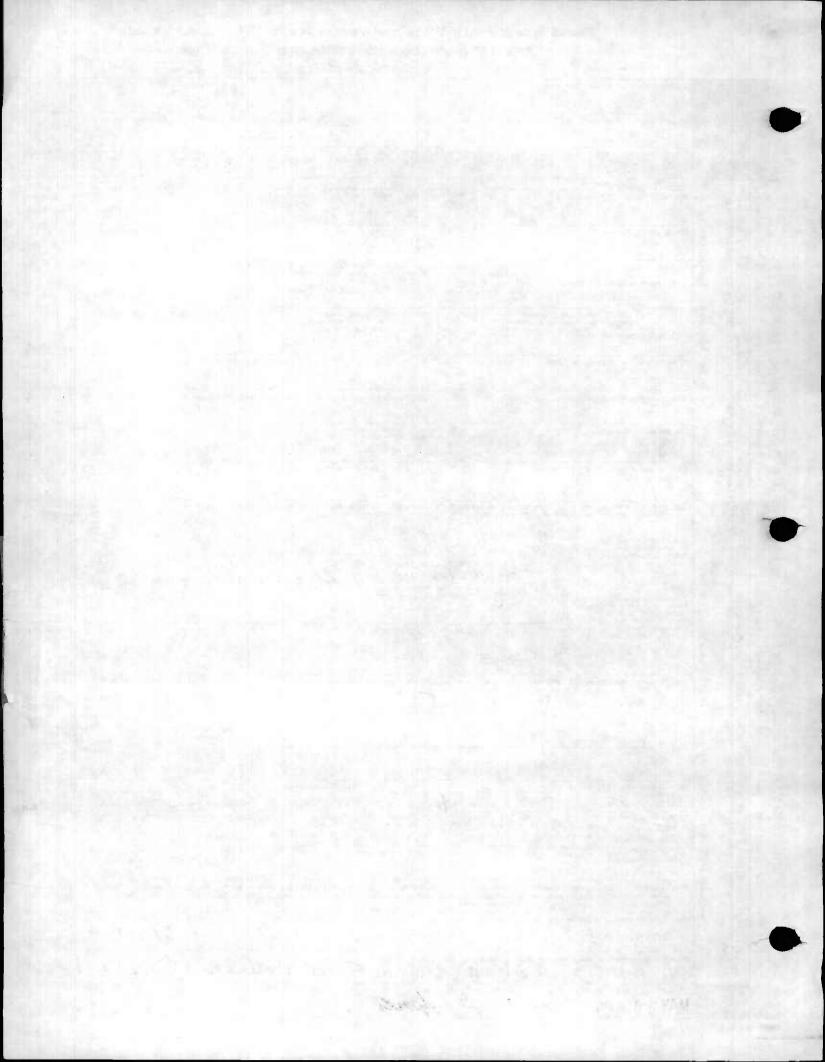
Registrar **DHMH 16 Rev 6/95**

31. Dete filed (Month, Day, Year)

30

SOME

32. Registrar's Signeture



00-2928-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. JOHN W. REED State of Maryland / Department of Health and Mental Hygiene ASP Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY Day 2000 Year **Physician** 27 1:30 A 0< /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Douth Examiner S. COLLINS BALTIMORE If Linder 1 Year If Undar 24 Hrs. 9. Birthplace (State or Foreign (Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 219-74-9036 1 M 2 F Yrs. Director Washington D. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show if Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Engineer must be notified at 1 Yes 2□No Funeral Director Mary land moi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than the state of the state 2/dx 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: AFFICAN by American 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) Elementary Secondary (0-12) 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ementin ree ora Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lio 22. Name and Addre Joseph 2222 orth ons-that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part / En **Physician** /Medical Immediate Cause (Final Gunshot disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner The law requires that the death certificate be executed the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 attending physician Physician/Medical Dua to (or as a consequanca of): 88 signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yss 2 No 3 Probably 45 Unknown Completed by 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? peen completion of cause of death? has 2 No 1/2 Yes 2□ No certificate Attending Physician: funeral director, 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence STOTHER (Specify) SCENE 1XXYes 2□ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how Injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending 1 Natural 1 Yas 2 No spital or Attenditions after death. death. investigation subject shot 5/27/00 130 A 2 Accident 281. Lécation (Street and Number or Rural Route Number, City or Town, State) 230 S. Cellius St 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Street To the Hospital o within 24 hours at To the Funeral D completely filled i Boltimore, Md edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

31. Date filed (Month Registrar

29b. Signatura and title of certifier

30. Name and address of person

Rnnis

32. Registrar's Signature

who completed ause of death (Item 23a) (Type, Print)

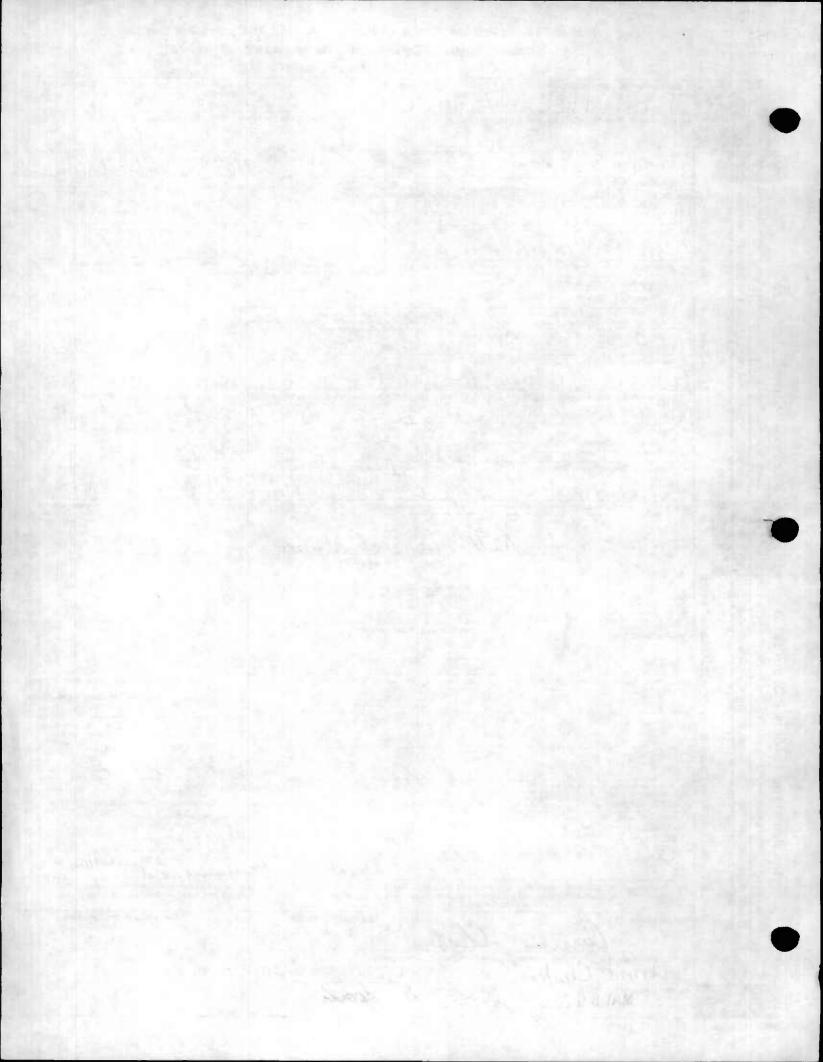
mis

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) MAY 27,2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death 2000 Yaer Josephine L. Russo 28 1:30pm May 4a Facility Nama (If not institution, give street and number) 4940 Ten Oaks Road 4b. City, Town, or Location of Death 4c. County of Death Dayton Howard If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) Sept 27 1908 Birthplaca (State or Foreign Country)
 NY 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 097-46-4464 1 ☐ M 2 🂢 F 91 Yrs. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Carroll Sykesville 1 ☐ Yas 2 No 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Quail Drive 21784 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2X No If Yes, Giva Year or Detes: 1 Never Married 2 Married specify.white 1 ☐ Yas 2 ☐XNo Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Gaetano De La Rosa 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Russo (son) 300 Quail Dr., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete Burial 2 ☐ Cremation 3 X Removel from State 6-2-2000 Brooklyn, NY Greenwood Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Haight Funeral Home & Chapel 21. Signeture of Funeral Service Licensee P.O. Box 195 Sykesville, Md 21784 23a. Part1 Enter the disease, or conshock, or heart failure. List only inplications that caused tha death. Do not entar tha mode of dying, such as cardiac or respiretory errest, by one cayse on each line. Approximata Interval Between Onsat and Daath tmmedieta Causa (Final ATHEROSCLEAUTE CARDIOVASCULAR DISEASE diseasa or condition resulting In death) 4 EARS Due to (or as a consequence of) Dua to (or as a consequence of) Dua to (or as a consequence of): Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown DEMENTIA 24b. Were autopsy findings evailable prior to completion of causa of deeth? 24a. Was en autopsy performed' 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Cothar (Specify) 1 Yas 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 1 SNetural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation Injury 1 Yas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide

Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or Nema 23a or 28a-f ahow adical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours attar death a Department of Health and Menial Hygiene. Important: if item 27 is marked other than "natural", or itema 23a and Injury or other traumatic event, the Medical Examples mass.

Physician /Medical

Examiner

physician and s the burial-transit

for use as 980

ate has been signed page 2 should be de

Director: After this cartific d in by the funeral director,

filled in by after

death.

To the Hospital o within 24 hours af To the Funeral DI completely filled in

Physician/Medicai

þ

Completed

8

Certification: To

The lew requires that the death certificate be executed

Box 68760.

Records, P.O.

of Vital Physician:

Division or Attending

21215-0020

Maryland

altimore.

Director

Funeral

É

Completed

8

2

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

25. Was casa rafarred to medical

28a. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 I Homicide

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titla of certifier

751860

29c. License number

29d. Date signed (Month, Day, Year)

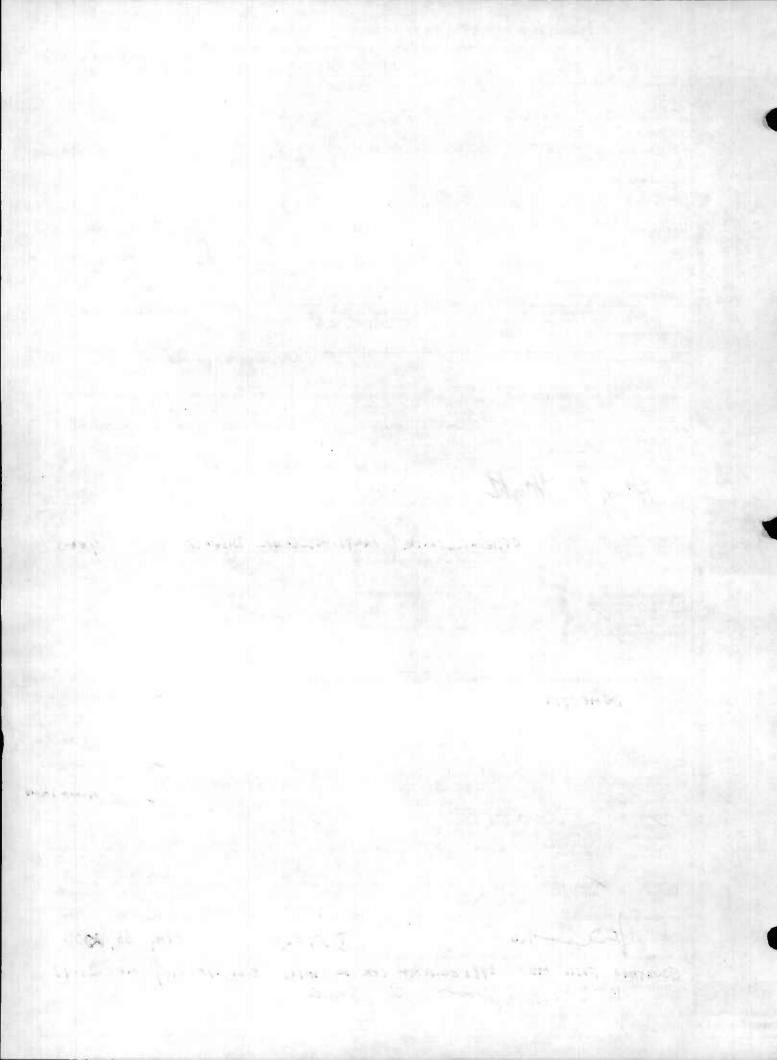
sss of person who completed causa of death (Item 23a) (Type, Print)

F1514 MD JONATHAN 31. Data filed (Month) Pay. 2000

3460 ELLICOTT 32. Registrar's Signatura

ELLICIT CIM MO con m #163

State Registrar



After this certificate has eral Director: After thi filled in by the funeral al or Attending P Division To the Hospital o within 24 hours af To the Funeral Di completely filled is

Registrar

2 Accident

3 Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day, Year)

MAY 3 0 2000

(Check only one) 29b. Signature and title of certifie

6 Could not be

28a. Date of Injury (Month, Day Year) 28b. Time of P FOUND M 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME

1 Yes 2 No

O.C.M.E.

UNKNOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State) 8 2 2 5 CURLEY ST BALTIMORE, CITY, MD.

2□ No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) and menner es stated.

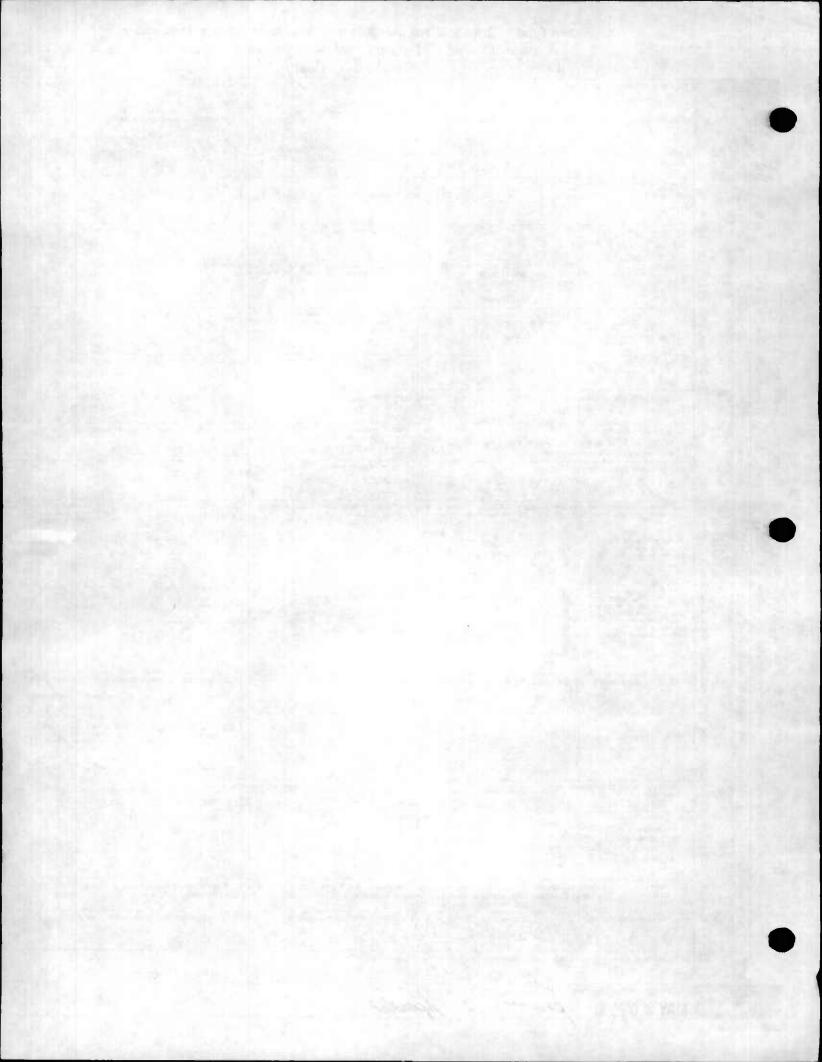
**Diffedical Examiner: On the best of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

MAY 25, 2000

who completed cause of death (frem 23a) (Type, Print)

reswell11 Penn Street, Baltimore, Maryland 21201 Oce

32. Registrar's Signature



RAAB, ARLENE Division of Vital Records,

/Medical Examiner The law requires that the death certificate be executed certificate has al or Attending Physical after deeth.

If Director: After this of in by the funeral d After this

Physician

/Medical

Examiner

Directo

Funeral

à

Completed

Funeral

Director

a 23a or 2

1 and 2 should be filed within 72 hours after Health and Mental Hygiens. em 27 is marked other than "natural", or lies

I Hygiene.

Department of Health a Important: If Item 27 is any injury or other trea

Physician

Pages 1

3aitimore, Maryland 21215-0020

To the Hospital o within 24 hours aft To the Funeral Di completely filled in State Registrar

DHMH 16 Rev 6/95

Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Diseasa or Injury that initiated avants rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. myocardial Infarction, Deep Venous Thrombosis, ð Be Completed Disseminated Intravascular Consulation 25. Was casa relarred to medicat examinar? 1 Yas 20 No Medical Certification: To 27. Manner of Death 1 (Divatural 2 Accidant 3 Suicide 4 Homicida 1 Dertifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one)

> Tamerlown, m.D D39763

2000 26

29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

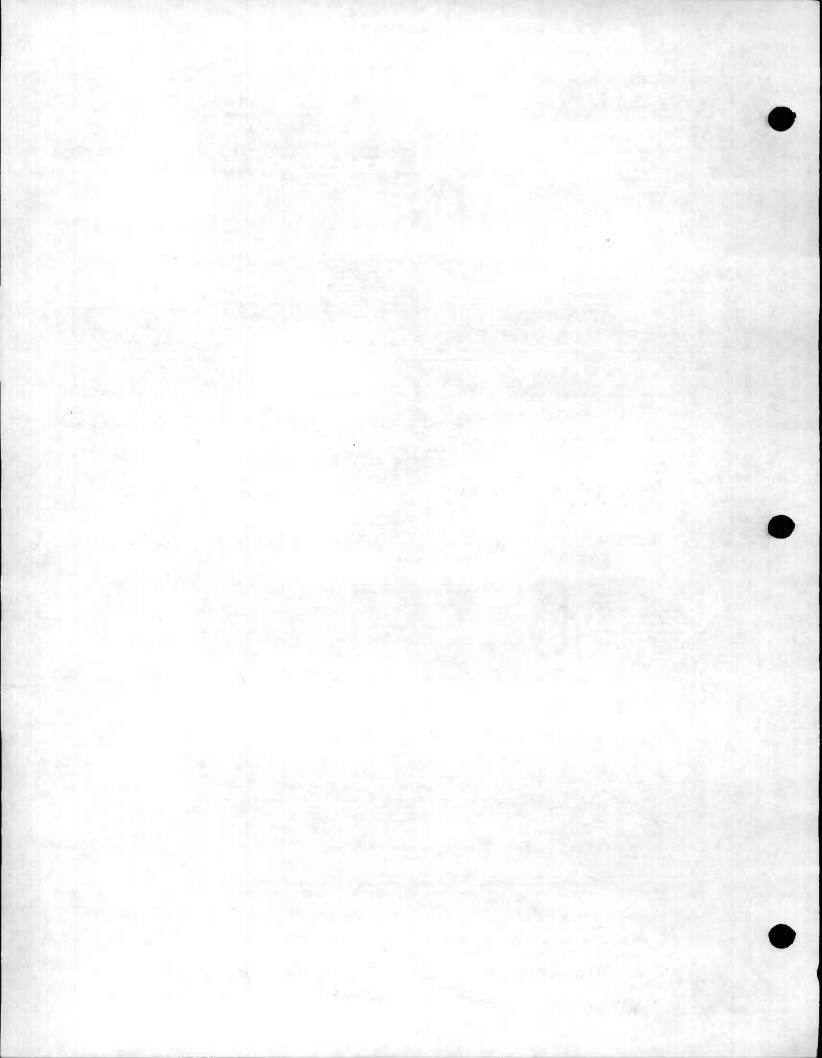
2012 Tollgate Rd, Suite 102, Bel AIT, MD 21015 Tannenbaum m.D. D. rocks

29c. License number

31. Data filed (Month, Day, Year)

29b. Signeture and titla of certifier

MAY 3 0 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth 136 Richardson Elaine Day 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) altimore paryland City If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country) N.C. 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2X F 77 220-22-9490 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□ No Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 501 Dolphin Street 21201 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Perry Essie Perry James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 N. Central St., Baltimore, Md. 21202 Gaylord Juanita 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removal from State 5/30/00 Lansdrown,e Md. 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 22. Name and Address of Facility Estep Bros FSPA 1300 Eutaw PL Balto, Md or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, sician s after de--1 Director: After -v the fr filled in by To the Hospital of within 24 hours a To the Funeral D

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Be Completed by

2

Funeral

Director

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	e End Stage b End Stage Durante Abcomin	y path a day a consequence of the consequence of th	l Disea Cancer Rtic Al	rse reurysm	Onset and Deeth
Part II. Other significant conditions on	entributing to death but not res	ulting in the underlying	cause given In Pert I.	23b. Did tobacco use cor 1 Yes 2 No 24a. Was an autopsy parlormed?	124b. Were eutopsy findings available prior to completion of cause
				1 ☐ Yes 2 ☐ No	of death?
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 €	YER/Outpatient 3□ D	OA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	er (Specity)
27. Manner of Death 1 A Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurr	red
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Special	ome, farm, street, facto (y)	y, office	28f. Location (Street and Numb City or Town, State)	er or Rural Route Number,
				e, end due to the cause(s) and ma urred at the time, date and placa,	

DHMH 16 Rev 6/95

State Registrar

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31. Date filed (Month, Day, Year)

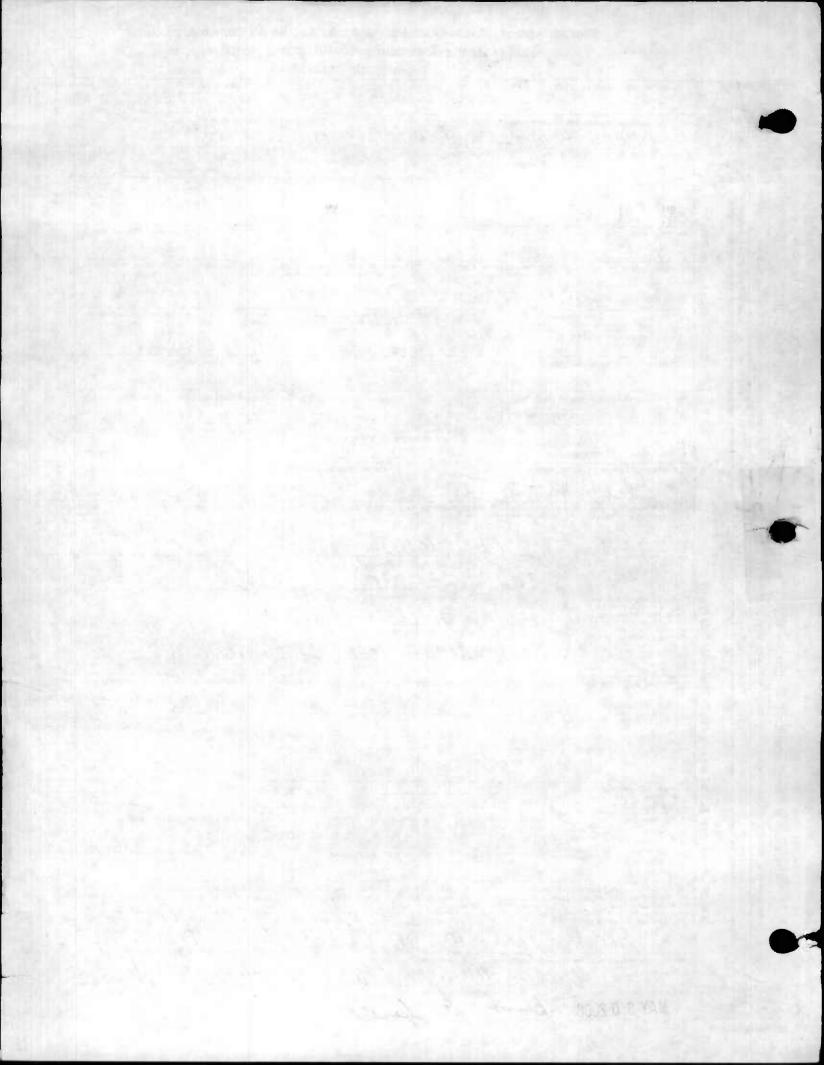
29b. Signature and title of certifier

32. Registrar's Signatura

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30. Name and address of person who completed cause of death (Item 23a) (Typa, Print) HMA+WN NACEM, MID, 40 VI

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer RITZ **Physician** 1- ARRY 1:10 A00 2614 2000 MAY /Medical 4c. County of Deeth
BALTIMORE 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** CENTER KANDALLSTOWN HOSPITAL NORTHWEST If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 12 M 2 ☐ F 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours 213-12-2703 98 Yrs. **Director** Jan. 2,1902 Maryland Usual Residence of Decedent death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 25s-f show other treumstic event, the Medical Evaniner must be notified at Baltimore Reisterstown 1 Yes 2 No Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21136 U.S.A. 1600 Nicodemus Rd. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Status Bleck, White, etc. filed within 72 hours efter 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Racetrack Horseman permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If fem 27 is marked othe any injury or other treumatic event, page. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Unknown Ritz 2 MNKNOWN 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) John Ritz - Son 1600 Nicodemus Rd., Reisterstown, Md. 21136 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete Lake View Mem. Park May 30, 2000 Sykesville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fuperal Fervice Licensee 22. Name and Address of Fecility Eckhardt Funeral Chapel 23a. Pertl. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, approximate shock, or heart failure. List only one cause on each line. Intervel Between Onset end Deeth **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical SEPSIS. Examiner Due to (or es e consequence of): Examiner AINOMUSING sician and bunial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es a consequence of): physician P.O. Box 68760. Physician/Medical thet Initieted events resulting in deeth) Lest use es the Due to (or es e consequence of) attending The law requires that the death for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? the 1 Yee 2 No 3 Probably WUnknown 3 signed t d be det HYPERTENSION Records, þ 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy page 2 should Completed peed performed' has 1 ☐ Yes 2 No 20 No 1 ☐ Yes certificate Division of Vital Hospital or Attending Physician: Be 25. Wes case referred to medical director 26. Place of Deeth (Check only one) exeminer Hospitel: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2D No this funeral 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Naturel efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) pletely filled in by 4 Homicide 24 hours 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner stated. edicai 29e. Certifier To the To the 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture with the of certifier 26TH 2000 7 42723 MAY NORTHWEST CENTER-HOSPITAL person who completed cause of deeth (Item 23e) (Type, Print) 30. Neme end eddre HARISH. HYVERA HALLI mD 21133 m RANDAUSTOWN 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

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New 30, 2707 Syke wille, Md.	Lobra View lem ork		Х
netel Chapel erstown 5d., Cutsom Hillm, No. 21117			3.5

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** George Harman Switzer, Jr. 11:00P.M 24,2000 194 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Rosedale Baltimore Franklin Square Hospital Center | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sep 12 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months 129 M 2□ F Yrs. 1919 216-05-3447 80 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show ttem 27 is marked other than "natural", or thems 23s or 28s-f show other treumstic event, the Medical Examiner must be notified as 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 8830 Walther Boulevard, Apt. 323 permit. Pagas 1 and 2 should be filed within 72 hours after death 1 Department of Hasith and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a any injury or other treumatic event, the Medical Examiner mass 1 any injury or other treumatic event, the Medical Examiner mass 1 and 1 21234 U.S.A. Funeral 14. Rece - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Georg (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tool and dye maker, designer | Manufacturing 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) George Harman Switzer, Sr. Rosine E. Langgood 19a. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) George Harman Switzer, 3rd - son 23 S. Oak Forest Drive, Okatie, SC 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Depation 5 ☐ Other (Specify) 5/27/2000 Easton, Maryland Woodlawn Memorial Park 22. Name and Address of Fecility 21. Signature of Funeçal Service Licenses Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximete Interval Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Anoxic Brain 12 hours disease or condition resulting in death) Examiner Due to (or es e consequence ot): Examiner Myocardial assive 12 hours The law requires that the death certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Łast Due to (or as e consequence of) Artery Box 68760. Coronary DISEGST Physician/Medical Due to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown hypertension by Records, 24b. Were autopsy findings available prior to completion of ceuse ot death? 24a. Was an autopsy performed? Completed this cartificate has 1 ☐ Yes 2 No 1 Yes of Vital al or Attending Physician: The safter death.

I Director: After this cartificate od in by the funeral director, pe Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3D DOA 27. Manner of Death 28c. Injury et Work? 28d. Describe how Injury occurred Division 5 Pending 1 Natural Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D complately filled in 29a. Certifier 1) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signeture end title of course 29d. Date signed (Month, Dey, Year) 29c. License number

Registrar

MAY 3 0 2000 **DHMH 16 Rev 6/95**

31. Date filed (Month, Dey, Year)

ORIGINAL

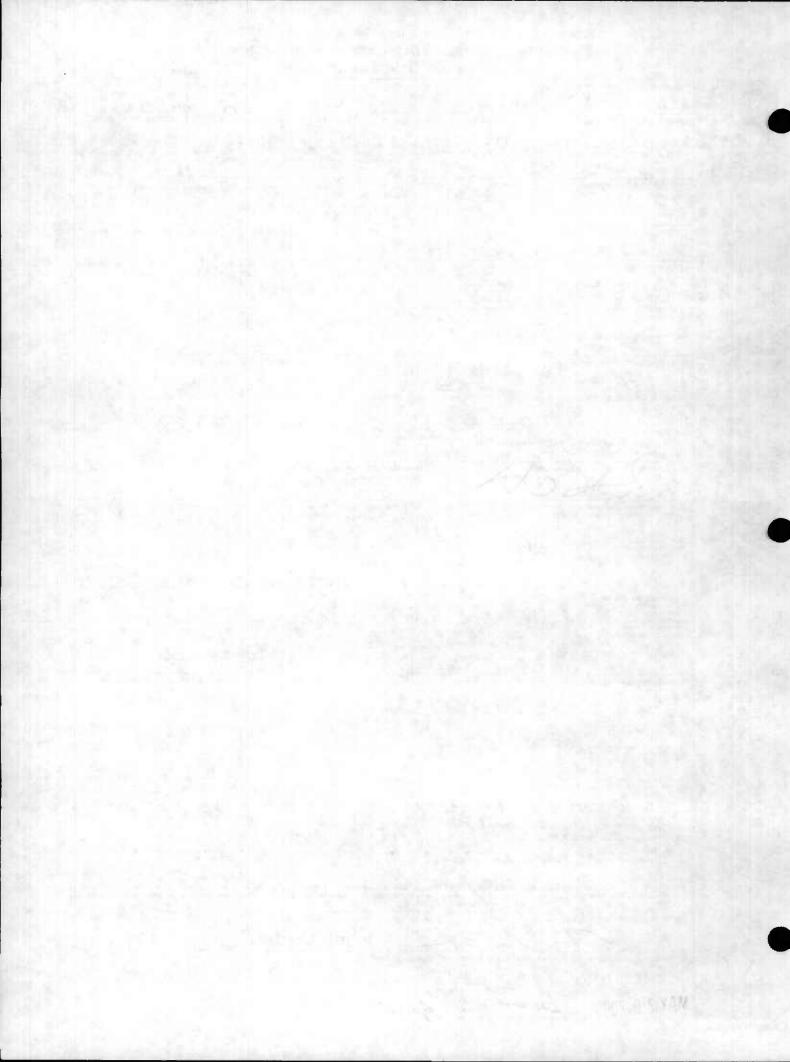
oaks

9000 Franklin Square Drive Baltimore, MD 2123

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

Geo-Philips Chacko



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Time of Death 4:30 p.m Month **Physician** 25, Jerome Sadowski May 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 915 Garden Drive #1A Essex Baltimore If Undar 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Days Hours 1♥M 2□F 217-20-8100 74 Director August 8, 1925 Pennsylvania Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo 28a-f Maryland Baltimore Essex 10g. Citizen of Whet Country? 10e Street and Number 10f Zin Code 23a or 915 Garden Drive #1A 21221 Funeral United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indien, Black, Whita, etc. 11. Merital Stetus hours after 1 Yes 2 No If Yes, Give Yaer or Detes: 1 Never Married 2 Merried 6 Maryland 21215-0020 1 Yes 2 No Specify: White Specify: by 3 □XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 8 Canning Company Factory Worker 18. Mother's Nema (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middla, Last) Be Pages 1 and 2 should be sent of Health and Mental Joseph Sadowski Josephine Bukoniewicz 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) . important: If item 27 any injury or other to Jean J. Serba - sister 827 Fairway Avenue, Catonsville, Maryland 21228 altimore, 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete Separtment of 1 ☐ Buriel 2 🖾 Cremetion 3 ☐ Removal from Stete Metro Crematory, Inc. 5/26/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signafure/of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 23a. Pert1. Enter the disaase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one sault on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in death) Examiner Examiner mari The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initiated evants resulting in deeth) Last Due to (or es e consequence of): pue Box 68760. Physician/Medical Dua to (or es a consequenca of): USB Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24b. Were autopsy findings available prior to completion of causa of death? 24e. Wes an autopsy performed? Completed rabell melliting pege 2 s 1 Yes 20 No 1 Yes 2 No of Vital Physician: 25. Was case referred to medical axaminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Neturel
2 Accident Division or Attending 5 Pending investigation after death.

I Director: After in by the fur 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28a. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 4 ☐ Homicide filled in To the Hospital of within 24 hours at To the Funeral D Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. edicai 29e. Certifler (Check only one) 29b. Signeture and title of certifia 29c. Licensa number 29d. Data signad (Month, Day, Year) 5.26.00

State Registrar 31. Dafa filed (Month, Dey, Year)

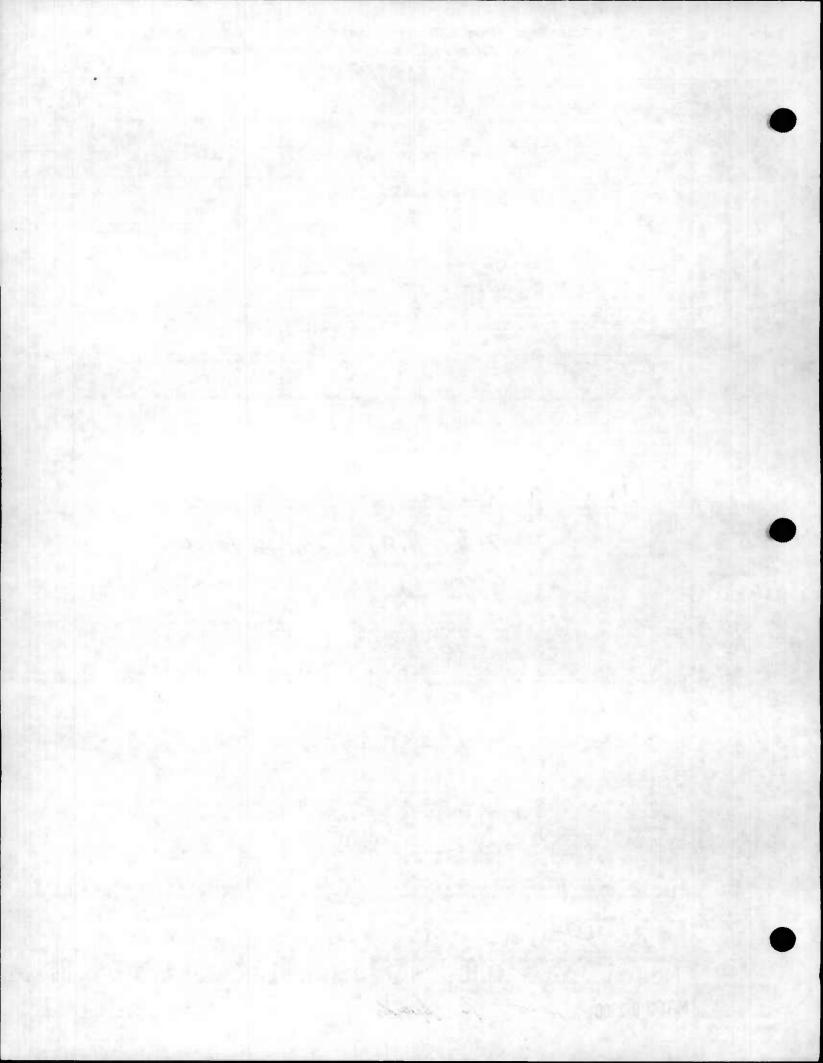
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Neme and address of person who completed cause of death (Item 23a) (Type, Print)

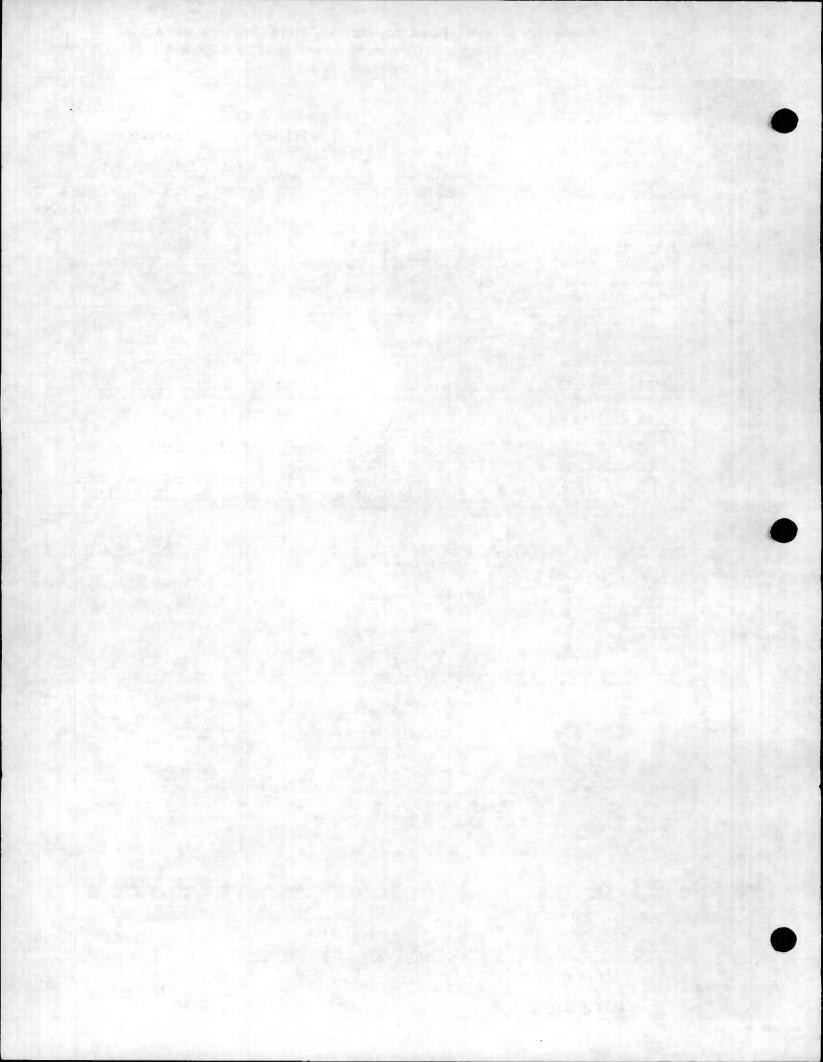
32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

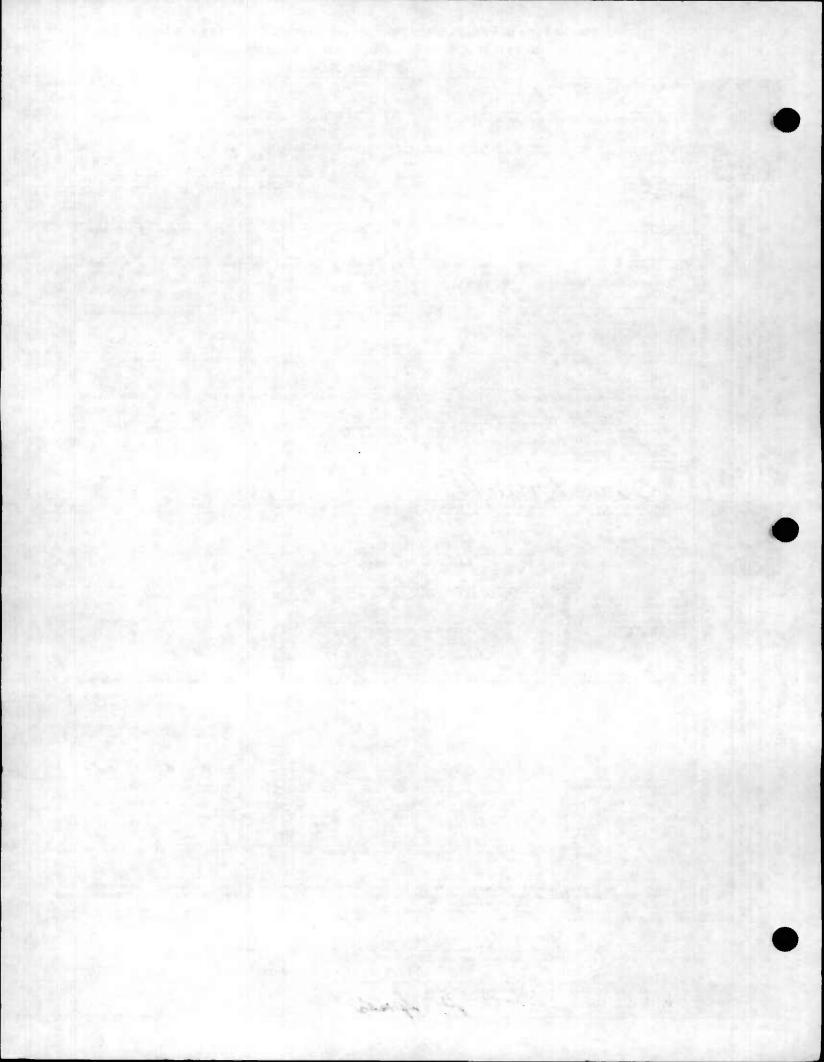
						Certif	icate of	Death	1000000	Reg. No.		0.7310
Physician /Medical	1. Decedent's Name (First, Middle, Last) Audrey May Szeliga								2. Date of Do Month May	Day 29	Year 2000	3. Time of Death 2:55 am
Examiner	4a Facility N	Facility Name (If not institution, give street and number) 4b. City, Town, or Baltimor								Location of Death 4c. County of Death		
		nklin Woo	ods Cente		n yrs. last bir	rthday) If	Under 1 Year	Baltimor	8. Date of Bi		ltimore	
Funeral Director	212-	03-6448 ence of Decedent		onths Days	Hours Min.				nplaca (Stata or Foraig untry) 1 Land			
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28a-f aho notified at	MD	Balt	imore		Middle River							1 □ Yas 2 N
ritems 23s or 28s-f show where must be notified at Funeral Director	10a. Street a	nd Number Wilson I	Point Roa	101. Zip Code Road 21220						en of What Co	untry?	
F, or the	3 Wid	itatus er Married 2 Ma owed 4 Divorce	rried 1 🗆 Y	Decedent Eve od Forces? (as 2 No s, Give or Dates:	er in U,S.		Decedent of his, specify Cub	Hispanic Origin? (S an, Mexicen, Puerl Specify:	pecify Yes or N to Rican, etc.)		4. Race - Ame Black, White Specify: Wh	
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d other event, b Be Cc	17. Father's	Nama (First, Middla	, Last)					18. Mother's Nar	me (First, Middle	a, Maiden S	Sumama)	
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t of Heelth at it from 27 is or other train	20a. Method	of Disposition			20h Place O	f Dispositio	on (Name of ory or other pla		Date	1	pation - City or	Town, State
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Department of Important: If any Injury or price.		re of Funeral Service	Po []	1	7	Danad	ley-Asl	ston Mott	hews Fu	neral	Home,	Inc.
1	23a. Part1. shock,	Enter the disease, cor heart failure. Lis	or complications to st only one ceuse	hat caused the	e death. Do	not enter th	ne mode of dyi	ng, such as cerdia	c or respiratory	arrest,	K FID Z	Approximate Interval Between
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CONTRACTOR OF	resulting In	oeatri)			e to (or as e			1.17418				8
physician and s the burial-transit	Sequentially if any, leading cause. Enter	list conditions, ng to immediate or Underlying lase or Injury	S b	Du	e to (or as a	consequen	ice of):					
e attending physician and dor use as the bunal-transician.		events	d	Due	e to (or as a	consequen	ce of):	A.	Tes Ca			
the attending hed for use a ysician/M	Part II Othe	r significant condit	lone contribution	to death but n	not resulting in	in the under	rhing cause di	ven in Part I	23h Dio	I tobacco i	use contribute	to the cause of deat
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ter this on neral direction. To		Death	28a. C	1 Inpatient Date of Injury Month, Day Y		tpatient Time of Injury	3 DOA 28c. Inju	4 Lunursing F	lome 5 ☐ Res 28d. Describe			city)
within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	2 Acc 3 Suid	ident invest	inot be 28e. F		- At home, fa			Yes 2 No	28f. Location City or To	(Street and	d Number or Ru	ural Route Number,
filled i	29a. Cartifie	r 17 Cartiful	ng Physician: To	the hest of m	ny knowledos	a death on	curred at the ti	me, date and place	and due to the	e causa(s)	and manner as	stated
Per Fur Pletely	(Check one)		f Examiner: On ti		amination an			opinion, death occu				
Within To the comp	29b. Signate	re and title of certifi		FOR D)		29c. Licen			29d. Date	e signed (Monti	-
	100					GA.	No	8358		5	130	1200
Q	30 Name ar	address of person	who completed	ceuse of deat	h (Item 23a)	(Typa, Prin	11) 70 ! BA	CT 1'K	CCIR	170	CARY	PARITICARIO.
State Registrar	31. Date file	MAY 3		32. Registrar's	Signature	4	bours	61			2/22	cx.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 7012 State of Maryland / Department of Health and Mental Hygiene

	ITEMS: #23 PART I 1. Decedent's Nama (First, Middla, L	ast)		3				2. Data of Death Month	g. No.	Yaar	3. Tima of Dea	
hysician /Medical	NATHAN A	ALEXANDER SM	IITH					MAY	28, 20	000	2032 P	
xaminer	4a Facility Nama (If not institution, gi JOHNS HOPKINS H						4b. City, Town, or Location of Death BALTIMORE CITY					
neral ector	5. Social Security Number 6.	Sax 1X M 2□ F 7. Aga (In	yrs. last birthd	Months	ar 1 Yaar Days	If Under Hours	24 Hrs. Min.	8. Data of Birth (Month, Day June 23	Year) 1994	9. Birthp Coun Mar	eleca (State or For etry) yland	
Director	Usual Residence of Decedent 10a. State 10b. County MD Carro		10c. City, Town or Location Eldersburg									
be notified Director	10e. Street and Number		101. Zip Code					10	g. Citizen of V	Part Cour	1 🗆 Yas 🗶 🗆	
remarks or	6122 Oak Hill Dri		re						USA			
by Fu	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Detes:	in U,S. 1	3. Was Dec If Yas, sp			gin? (Spe i, Puarto l	cify Yes or No- Rican, atc.)	Blac	- Americ k, White, : Whi:		
t, the Medical En-	15. Decedent's E (Specify only highest g		(G	cedent's Us	rork done	during most	t of worki	ng 1	6b. Kind of Bu	sinass/Inc	dustry	
und und	Elamantary/Secondary (0-12)	Collega (1-4or 5+)		a <i>bo Not</i> Studen		od)			Eleme	ntar	v	
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To Be	Ronald Kenneth	Smith				1.54	Vick	i Lynn H	Kindia			
ĒĒ	19a. informant's Name/Ralationship	(Type, Print)	19b. M	ailing Addra	ss (Strae			l Routa Number,		Stata, Zip	Coda)	
or trau	Mr. & Mrs. Ronal	ld Smith (par	ents)	6122	Oak 1	Hill D	rive	Eldersh	ourg, M	D 21	784_	
uny or other	20a. Mathod of Disposition 1 XBurial 2 Cramation 3 4 Donation 5 Other (Special Control of Control	Ramoval from Steta	Ob. Place of Di	sposition (No	ame of other pla	ice)			Oc. Location -	City or To	own, Stata	
any Injury o	21. Signatura of Funarel Sarvice Lice	R. Haid	4	HAIG	HT F	ass of Facilit UNERAL Le. MD	HOM	E & CHAF 84 (410)	PEL, PA	(Box	x 195)	
dical niner	Immediata Causa (Final disaasa or condition rasulting in death)	a. Due	IAC ARR	sequance of):					1	Onset and Deat	
physician and strength strengt	Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Diseasa or Injury	D	O ANOMA to (or es e con			CORN	ARY	ARTERY	18		N-M-	
E .	Cause (Diseasa or Injury that initiated evants rasulting in death) Last	CDua	to (or as a con	sequanca of):							
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2 should pleted								24a. Was ar perform		av	ere autopsy findi allabla prior to impletion of causi death?	
page 2	Berry Willer and The							1/2PYa	s 2 No	19	Yas 2□ No	
Be Sctor	25. Was case refarred to medical axaminar?	Hospitat:		177	0	har-		(Check only on				
T di	1 X Yas 2 No 27. Manner of Death	1 L Inpatient	2 ER/Outpe		JUA	4UNU	- 1	ma 5 Rasida 28d. Describe ho			(y)	
in or	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	be 300 Place of Injune		M		Yas 2	No				a <i>l Rout</i> a Num <i>ber</i> ,	
led in by the Certificat	4 ☐ Homicida datarmina	building, etc. (5	pecify)					City or Town	, Stata)			
completely filled in	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exu	hysician; To the best of my miner; On the basis of exa and manner states.	knowledga, d mination and/o	aath occurre r Invastigatio	d et the t on, in my	ime, date an opinion, daa	d place, atth occurr	and dua to tha ca ed at tha tima, da	use(s) and ma ita and place,	nnar as s and dua t	staled. o the cause(s)	
d comb	29b. Signatura end titla of certifiar	1961	/	2		sa number ME	ħ.		od. Data signa MAY 29			
	30. Nama end addrass of person who	complated causa of death		pe, Print)			2					
	/ / //	m / -	1.1	1 De-	O.L.	mark '	D-74	imore, M		2 222	001	



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyoiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Da May 26, 2000 Year Physician В June Shaver 1:55pm /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Yrs. 212 28 4276 Director October 13,1928 Glen Arm, Maryland Usuat Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? real ber 2105 Bellvale Road 21047 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Maryland 21215-0020 b Specify: White 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) parmit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygene. Important: If Isem 27 is marked other than ** any injury or other treumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) NA 12 Assistant Secretary Black & Decker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton Arnold Burton Helen Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) G David Shaver (Son) 2105 Bellvale Road Fallston, Maryland 21047 Baltimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens May 30,2000 Bel Air, Maryland 22. Name and Address of Fecility ture of Funeral Service Licenses E.F. Lassahn Funeral Home PA 11750 Belair Road Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death Physician tmmediate Cause (Finet disease or condition resulting in death) /Medical nonth Examiner Due to (or es a consequence of) Attending Physicien: The law requires that the death certificate be executed physician and s the bural-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) US0 88 signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown à cate has been signate, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Special 6 Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA th th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 5 Pending 1 Natural death. 1 Yes 2 No 2 ☐ Accident investigation Hospital or Attend
 24 hours effer death
 Funeral Director; / 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) filled in by 4 Homicide tic Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) the th 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura 25205 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

11) A-A-Ley (-BMC 6721 Ne Challes St. Balto Md 2120) Ghma 6721) A-Riler

Registrar

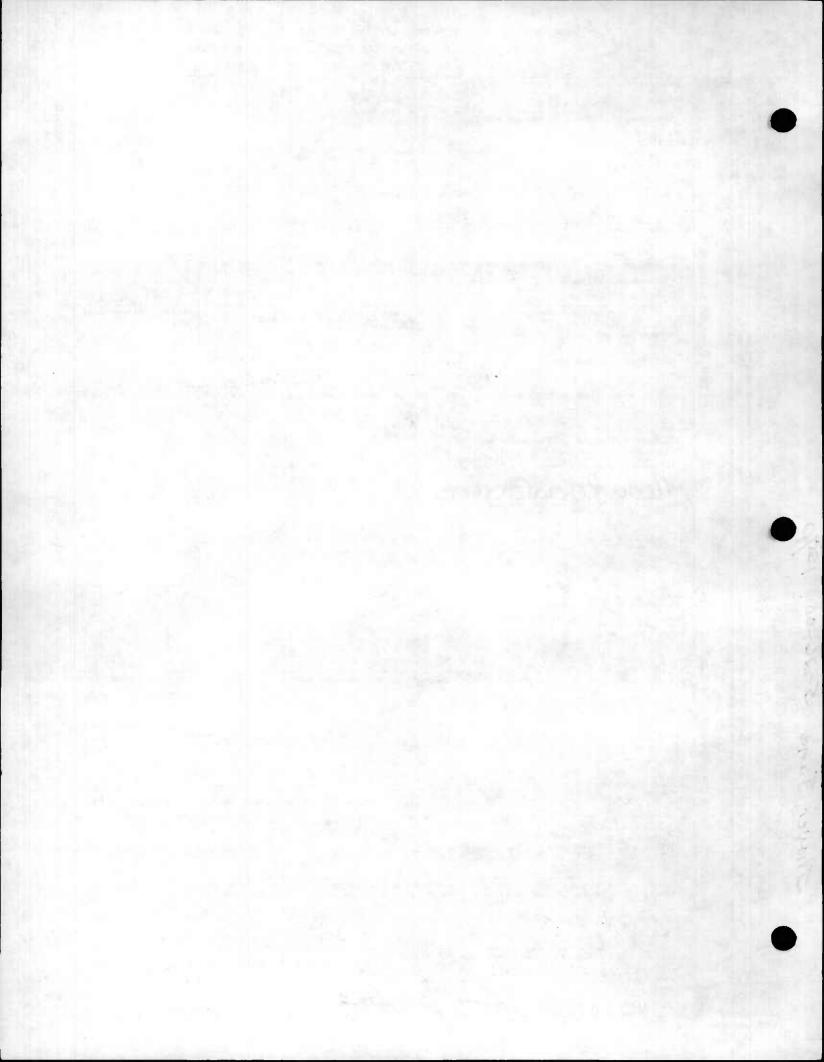
State

31. Date filed (Month, Day, Year)

MAY 3 0 2000

Darks

32. Registrar's Signature

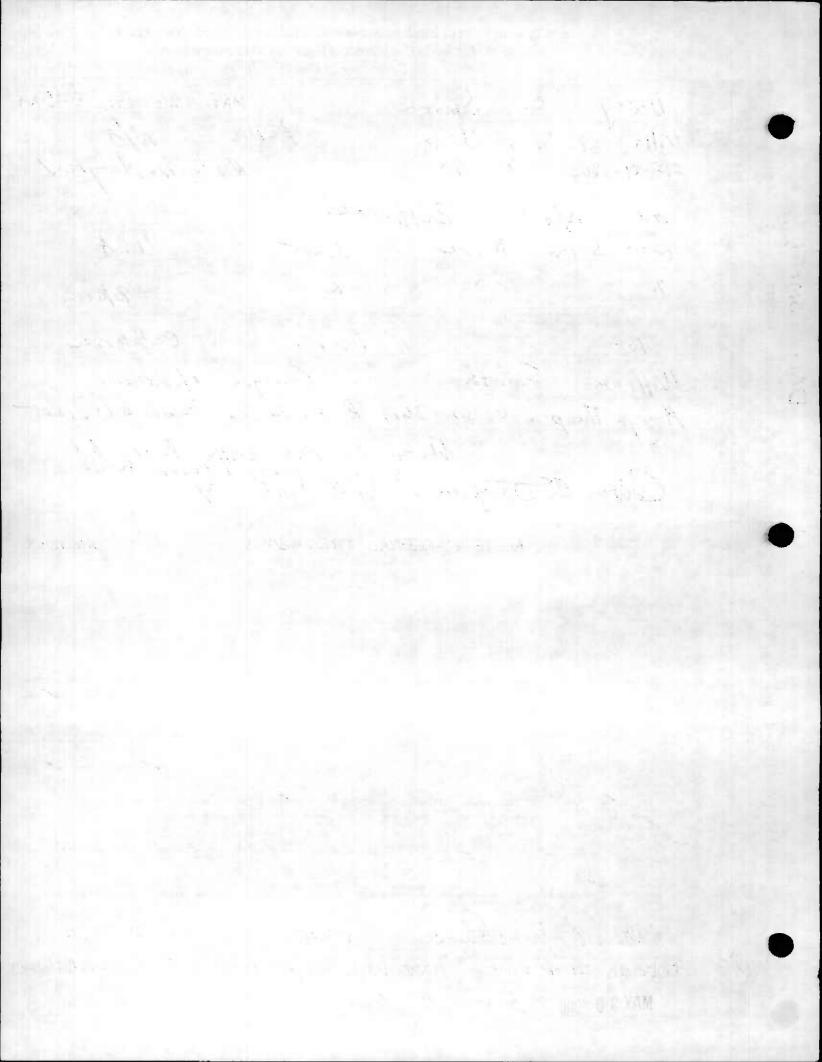


*	Phys /Me Exa					
Box 68760,	is that the death certificate be executed					
	death					
s, P.O.	thet the					
w	97					

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY **Physician** 5:15 AM 26 am ans /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day sako Kaels 6. Sex 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 3 Deys Months 1 ■ M 2 F 215-24-5660 Usual Residence of Decedent Yrs. Director land 5660 aru death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryle Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "naturel", or items 23s or 28s-1 show any injury or other treumetic event, the Mariteal Exercities inval be notified at once. 1 Yes 2 □ No Director md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4200 Seton Funeral 12. Was Decedent Ever in U,S. Armed Forces?

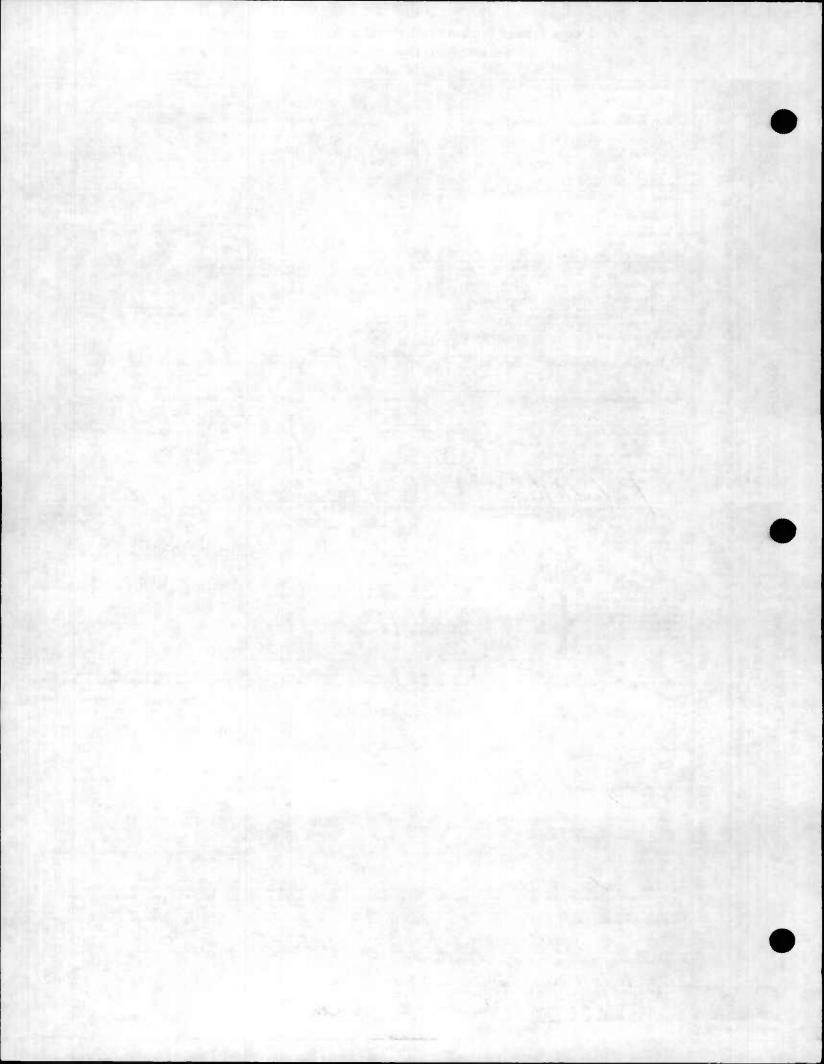
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 2☐ Married 1 Never Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed /ack 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT_juse retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name /First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Be 2 1 am 19a. fnforment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number of Rurel Route Number, City or Town, State, Zip Code) 3619 Cousin Osedate ≥alto. Merv Mompson 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 Bunal 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1701 C 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death ician Immediate Cause (Final disease or condition resulting in death) dical ACUTE CEREBRAL THROMBOSIS ONE HOUR niner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) been signed by the e should be deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 DUnknown 1 ☐ Yas 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? Division of Vital Record 24a. Was an autopsy Hospital or Attending Physician: The law requir performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 € No certificete funeral director, 25. Was case referred to medicel exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Date of fnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. fnjury at Work? 1 Maturel 5 Pending s efter death. 2 No 1 Yes 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours of To the Funeral D 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 26, 2000 H45931 MP 30. Name and address of person who completed couse of death (Item 230) (Type, Print)
Deborah Irene Pierce 7220 Park Heights Avenue Baitmore MD 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signatuse State MAY 3 0 2000 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 7 7 7 5

			(Certificate of	Death	F	Reg. No.				
	1. Decedent's Neme (First, Middle,	Last)				2. Dete of Dee Month	th Dey Ye	3. Time of Death			
Physician /Medical	EMMA M.	TULLY				MAY	25 2000				
Examiner	4a Fecility Name (If not institution,	give street and number)			4b. City, Town, o	r Location of Deeth	4c. County of D	Deeth			
	4711 Mawani Rd.				Baltimo:	re County	Balti	.more			
Funeral Director	5. Sociel Security Number 212-01-0985 Usuel Residence of Decedent	. Sex 7. Age 1	(In yrs. last birtho	Months Day		n. (Month, Des	8,1911 Sirthpleca (State or Foreign Country) Maryland				
pue & w	10a. Stete 10b. County		10c. City, Town o	r Location				10d. Inside City Limits			
or 28s-f she be noursed	Maryland Baltin	nore			imore Co			1 □ Yes 2 No			
23a or	4711 Mawani Rd.			10f. Zip Code	21206		10g. Citizen of Wha				
Hygiene. ther than 'natural', or thems 23a or 23a-f show but, the Medical Evanther must be notified at the Completed by Funeral Director	11. Meritel Stetus 1 Never Married 2 Married 3(C)Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1	ever in U,S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		(Specify Yes or No- erto Rican, etc.)	14. Rece - / Bleck, V	Americen Indien, White, etc. Ihite			
ygiene. Nor than "neturn ft, tra Mexical Completed	15. Decedent's (Specify only highest	grade completed)	((ecedent'a Uauel Occ Give kind of work don fe. DO NOT use retii	upation e during most of w	orking	16b. Kind of Busine	ess/Industry			
then	Elementery/Secondery (0-12)	Coilege (1-4or 5-	+}	al Secret			John Robl	en,Attorney			
Hygin Sther	17. Father's Neme (First, Middle, La			,		eme (First, Middle,		en, Accorney			
nd Mental Hygiene. marked other than imatic event, tre. M. To Be Comp	George W. Spind	ler			Emm	a A. Herr	emann				
0 .5 4	19e. Informent's Name/Reletionahij			Meiling Addresa (Stree				te, Zip Code) 21237			
them 27 i	20a. Method of Disposition		20b. Plece of D	isposition (Neme of cremetory or other p	la cal	Dete	20c. Location - City	y or Town, State			
	XX Burial 2 Cremetion 3 4 Donetion 5 Other (Spe			nurch Ceme	_	-27-00	Baltimore	Md.			
Department of mportant: If any Injury or ance.	21. Signeture of Eunerel Service Lic		22011 01	22. Neme end Add	,	2, 00	Darozmore	, , , , , ,			
de la	1 9 1 11	11.		Lassahn			e, Md. 21				
ding physician and use es the buriel-transit	Sequentially list conditiona, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	. ASH	Oue to (or es e cor Due to (or es e cor Ca · B	requence of): I PEV FCM.	see h	COLD	+ Ca-	Cours			
for for	Pert II. Other eignificant conditions	contributing to death bu	t not resulting in th	ne underlying cause g	jiven in Pert i.	23b. Dld t	obacco use contril	bute to the cause of death?			
						101	Yee 2 No 3 Probably 4 Unknow				
2 should		0:				24a. Wes		4b. Were autopsy findings available prior to completion of cause of death?			
page page						1 D Y	es 200 No	1 ☐ Yes 2 ☐ No			
s certificata director, pay To Be Co	25. Wes case referred to medical examiner?	26. Place of Death (Check only one)									
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ath. r: After th he funeral ation:	27. Menner of Death 1. Netural 5 Pending 2 Accident investiget	28a. Dete of Injur (Month, Dey	Year) 28b. Tim inju	iry W	ork? 28d. Describe how injury occurred						
al Director: After is ed in by the funeral Certification:	3 Suicide 6 Could no determine		ury - At home, ferm, street, fectory, office c. (Specify)				28f. Location (Street end Number or Rurel Route Number, City or Town, State)				
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29e. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of end menner stell	examinetion and/o	eeth occurred et the or investigation, in my	time, date end ple opinion, deeth oc	ce, end due to the courred at the time, of	ceuse(a) end manne dete end plece, end	er es staled. due to the ceuse(s)			
ro the	29b. Signeture end title of certifier			29c. Licer	nse number		29d. Date signed (N	fonth, Day, Year)			
1	1000	NE		1	1508		5- 21	-00			
.6	30. Neme and eddress of person wh	o completed cause of de	eth (Item 23e) (Tu	roe, Print)	15000		J 26				
State Registrar	MESBAH DO 31. Dete filed (Month, Dey, Year)	WLA M. O	r's Signeture		lway.	St#409	BALTO	5, 21231			



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Lest) 2. Data of Death 3 Time of Death Yaar **Physician** DELMA UPTON MAY 26, 2000 11:55 am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE CHESAPEAKE ANNE ARUNDEL ARNOLD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Data of Birth (Month, Day, Year) Birthpiaca (Stata or Foreign Country) 7. Aga (In vrs. last birthday) **Funeral** Months Days Hours 1□M 2ĬĬF Yrs 215-05-4425 Director 90 APRIL 16,1910 MARYLAND Usual Rasidance of Decedant the Maryland 10a. Stata 10b County 10c. City. Town or Location 10d. Insida City Limits ahom r 28a-f ahow 1 ☐ Yas 2 No **Funeral Director** MARYLAND ANNE ARUNDEL PASADENA 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? death with than "netural", or itams 23s or the Medical Examiner must be 8850 FORT SMALLWOOD ROAD 21122 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-lif Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. Peges 1 and 2 should be filed within 72 hours after in ant of Health and Mental Hygiene. Int: If flem 27 Is marked other than "natural", or its 1 Nevar Married 2 Married Saitimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify Be Completed by 3 X Widowed 4 Divorced Yaar or Datas WHITE 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) SALES REPRESENTATIVE SEWING MACHINE CO. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) TURNER R. WATSON LULA I. UPTON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Peges 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau SHIRLEY RIST-SISTER 3518 LAKE WAY, ELLICOTT CITY, MARYLAND 21042 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removat from Stata 4 ☐ Donation 5 ☐ Othar (Specify) FRIENDSHIP CEMETERY 5/29/00 HANOVER, MARYLAND 21. Signatuse of Funeral Service Licenses 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 M01234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tntarvat Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Dua to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner onea The law requires that the deeth certificate be executed the burial-tran Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disease or injury that in itiated avents rasulting in death) Last Dua to (or as a consequence of) of Vital Records, P.O. Box 68760, Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not rasulting in tha underlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 Unknown 1 Yes 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy certificate hes 2/2 No 1 Yas 1 □ Yas 2 □ No or Attanding Physician: 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) 1 Yas 20 No Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) To the Hospital or Attanding responsibility to the Funeral Director: After this c 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28c. tnjury at Work? 28d. Dascribe how injury occurred Division 5 Panding invastigation 1 Natural Injury 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Piace of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number of person who complated causa of death (Itam 23a) (Type, Print) BUY, PASADENA, MO 21122 RIAE-M-D 8109 RITCHIE filed (Month, Day, Year)

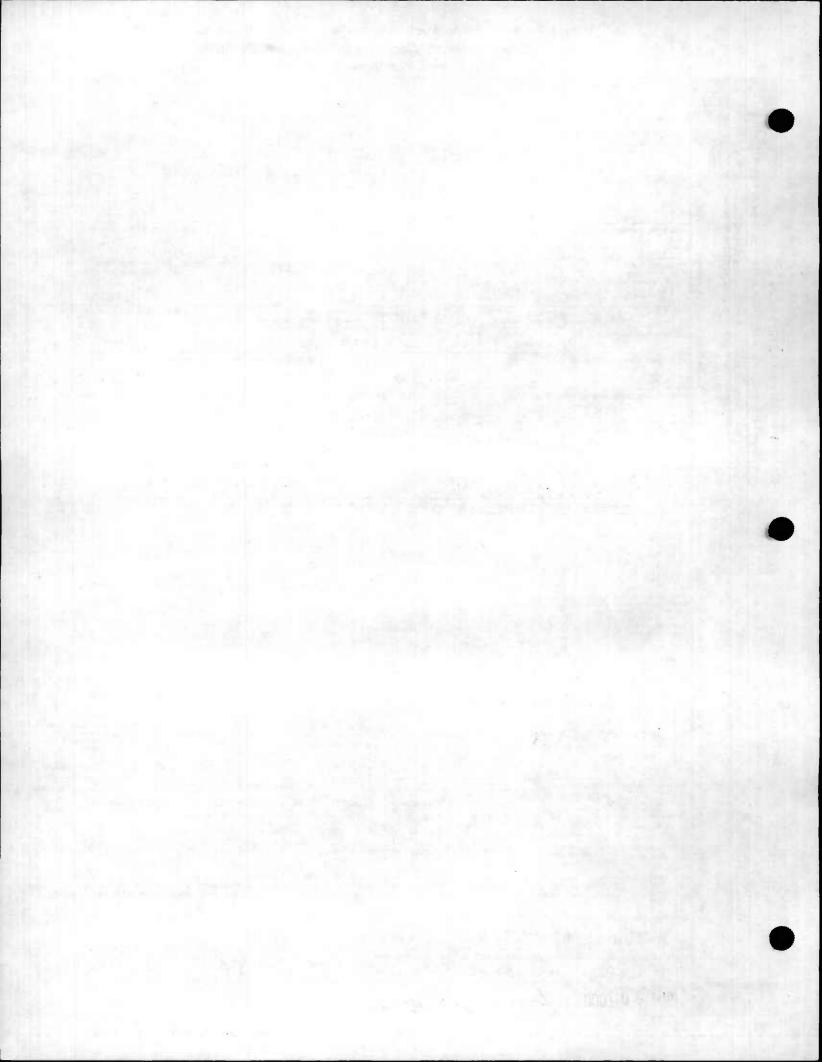
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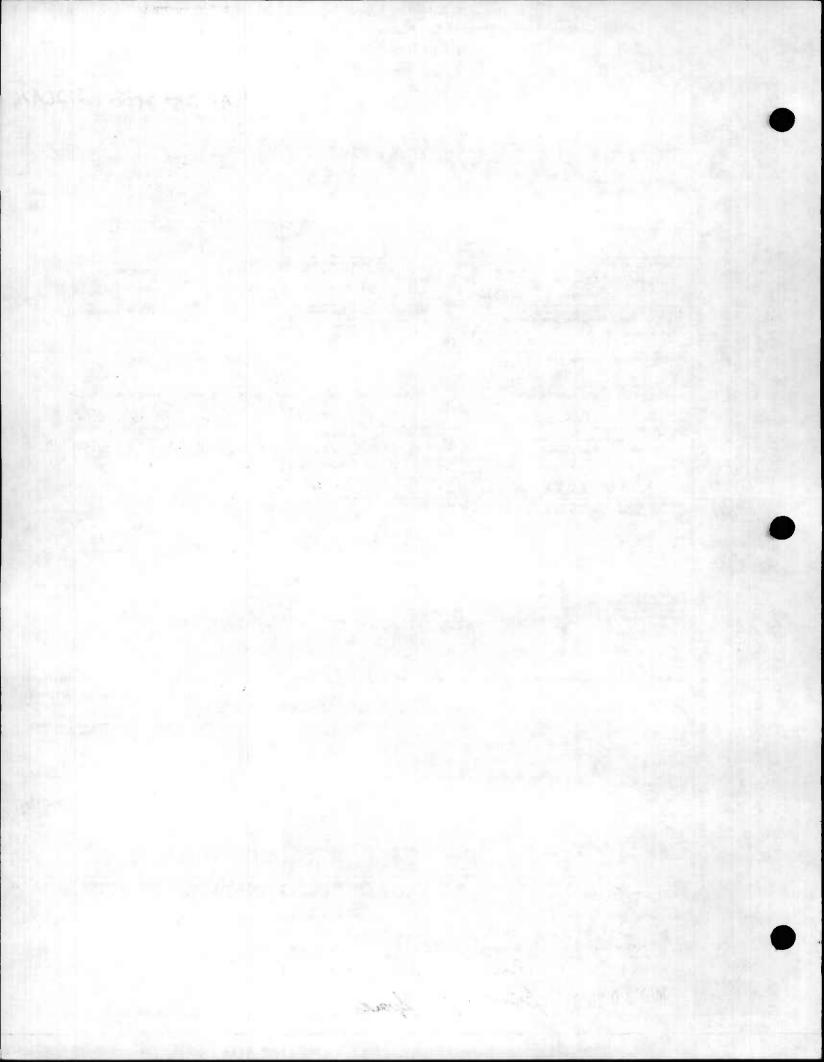
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32. Registrar's Signatura



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				Cert	tment of h ificate of			Reg. No	b .	1 / 0 1 /
1. Decedent's Name (Figure 1) ician Jimmy	irst, Middle, Las	1)	Will	iame			2. Date	VTE	Year A-ODO	1 1 1 1 1 1 1
dical 4a Facility Name (If not	institution, giva	street end nur		Lamb		4b. City, Towr	n, or Location of	Death 4	County of De	
Stella I	Maris	@ Mer	y Hos	pice		Balt	imore		N	IA
5. Social Security Number 212-34-4		x □M 2□F X	7. Age (In yrs. 62	last birthday) Yrs.	If Under 1 Yeer Months Days	If Under 24 Hours	Min. (Mo	of Birth oth, Day, Year 29-38	9. B	irthplace (Stete or Foreign Country) MD
Usual Residence of Dec	edent c. County		10c City	, Town or Loca	ation					10d. Inside City Limits
	NA			ltimor						1 Ø Yes 2 □ No
10e. Street and Number 1128 Mon 11. Marital Status 1 Never Married					10f. Zip Code			10a. C	tizen of What C	Country?
1128 Mon	tpelie	r Str	eet		2121	8			USA	
11. Marital Status		12. Was Dece Armed For	dent Ever in U,		as Decedent of h Yes, specify Cub	tispanic Origin	n? (Specify Ye	s or No-	14. Race - Arr Black, Wh	
1 Never Married 3 Widowed 4		1 🔀 Yes If Yes, Giv Year or Do	2 □ No a	he i	Yes 2XXXIII	Specify:	outo i noun,	,,,,,	Specify:	Black
15.	Decedent's Edi	ucation		16a. Decede	nt's Usual Occup	pation		16b. I	(ind of Businas	
Specify or Elementary/Secondary 10th Gra	nly highest grad	le completed) College (1	-4or 5+)	(Give ki	nd of work dona NOT use retire	durina most a	of working			
10th Gra		NA	401 04)	Tru	ick Dri	ver		C	ompany	Y
17. Father's Name (First	t, Middle, Last)					18. Mother's	s Name (First,	Middle, Maide	n Sumeme)	
0	Ur	known				Mabe			Will:	
19a. Informant's Name/I										. Zip Code) 21218
Mary Hol		lillia		1128 lace of Disposi		lier	Street		imore,	, Maryland
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23a. Part1. Enter the dishock, or heart fail Immediate Cause (Final diseasa or condition resulting in daath) Sequentially list condition if any, leading to immediate cause. Entar Underlying Cause (Disease or injur) that initiated events resulting in death) Lest		a.	1		todsh			more		Approximata Intarval Between Onset end Deeth
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Cause (Disease or injury that initiated events resulting in death) Lest	1	c	Due to (or	es e conseque	ence of):					
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Carlo										1
Part II. Other significant	conditions co	ntributing to de	ath but not resu	ilting In the und	lerlying causa giv	ven in Part I.	23		_/	te to the cause of death?
			7					1 Yes	2UNo 3	Probably 4 Unknown
Completed by							24	a. Was an auto	opsy 24b	. Wara autopsy findings available prior to
						_	-	performed?	,	completion of cause of daath?
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25. Was casa referred to examiner?	medical					26. Placa o	of Death (Checi	k only ona)		
1 Yes 2 No				ER/Outpatient	3□ DOA Oth	ner: 4□ Nurs	ing Home 5 (Residenca	6 □Other (Sp	pecity) hospily
27. Manner of Death	Pending	28a. Data o (Monti	f Injury h, Dey Year)	28b. Time of Injury	28c. Inju			scribe how inju	iry occurred	
2 Accident 3 Suicida 6	Investigation Could not be determined	28e. Placa	of Injury - At ho	me farm stree	M 1 □	Yes 2 □ No		ation (Street e	nd Number or	Rurel Route Number,
4 Homicide	determined	buildir	ig, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			or Town, Stal		
29a. Certifier (Check only one)	Certifying Phy Medical Exami	ner: On the ba	sis of axaminat	vledge, death o	occurred at the ti- stigation, in my o	ma, data and popinion, daath	place, and due occurred at the	to the cause(se time, date an	s) and manner of place, and d	as stated. ue to the cause(s)
29b. Signeture and title of	of certifier	and mann	er stated.		29c. Licens	a number		29d D	ate signed /Mo	nth, Day, Year)
Du	An	2 no				0854	1	230. 00	5/25	la
	f narean who a	Ompleted cours	of death (tra-	23a) (Tuna B					3 3	3
30 Name and address of		AUGUSTER CHUS	NOTE:	ZJEJ LIVDO, P	mm.i		^			
30. Name and addrass of	Jan 6	17	ebers	301	S+ P.	al P	1 15	ultima	Jus 3	Suc)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) Day Month Yaar WILLIAMS 5:38 PM nau 21 EDWARD 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 900D SAMARITAN MA BALTI MORE HOSPITAL If Undar 24 Hrs. If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (State or Foreign Country). 7. Aga (In yrs. last birthday) 6. Sex Days Months Hours AM 20 F 218 04 4406 85 Mary sup Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 das 2 □ No BALTIMORE Mary Ino 10f. Zip Coda 10g, Citizen of Whet Country? 10e. Street and Number 21239 USA 1364 ENHIDGE Kerso 0 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 11 Marital Status 1 Nevar Married 2 Married 1 ☐ Yas 2 No If Yas, Giva Specify Black 1 ☐ Yas 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Blue Gross Blue SKIGOT Elementary/Secondary (0-12) Collega (1-4or 5+) OFFICE MANAGER 114 grede 17. Father's Nama (First, Middle, Last) 18. Mother's Nema (First, Middla, Maidan Sumema) OSBORNE WILLIAms 11. LEUGRING 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 1364 PENTRIDGE RUMP /wife Both MOR. Mary low HELEN E. WILLIAMS 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Date 2 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from State 22 Nama and Address of Facility CHA THEM HARRIS 3240 RUSTERSTUWN RAMS TIMONIUM 4 □ Donation 5 □ Othar (Specify) FUNERAL HONE 21. Signatura of Funaral Service Licensea Hurris Md 21 218 BAH min, 23a. Part T. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in deeth) UROSEPSIS Due to (or as a consequance of) HEMATURIA Dua to (or as a consequence of): EMMOLISM PULMONARY Due to (or es a consequence of): 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

Physician /Medical Examiner

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page 2 should

The law requires that the death certificate be asscuted

Physician:

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To the Hospital of within 24 hours a To the Funeral D completaly filled its annual completal of the following the following to the following t

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Division or Attending **Physician**

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23a or

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens.

Hygiene.

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Department of Important: If any Injury or

21215-0020

Baltimore, Maryland

Physician/Medical Examine þ Be Completed edical Certification: To

Sequentially list conditions, if any, leading to immadiata ceusa. Entar Undarfying Cause (Diseese or injury that initiated avents resulting in death) Last

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to complation of causa of daath? 283 No 1 ☐ Yas

25. Was casa rafarred to medice! 1 Yas 2 No 27. Manger of Death 1 Natural

2 Accident

3 Suicida

29a. Certifier

4 Homicide

5 Panding Invastigation 6 Could not be datarmined

Hospital: 12 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year)

28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Yas 2 No

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

26. Placa of Death (Chack only ona)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifiar

29c. Licansa number 712356 29d. Data signed (Month, Day, Year) 21,2000

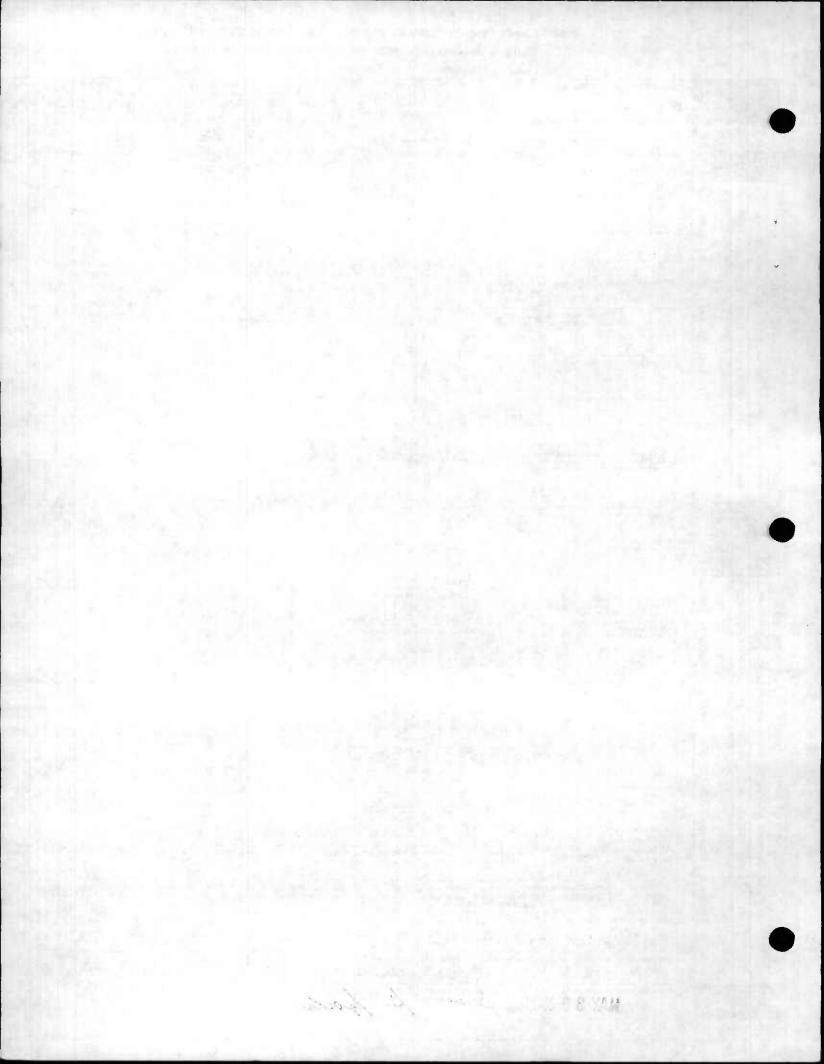
30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) S601 Lock Newer Blud. BALLINGE ND 21239 Cleria Negrini, MD -

Cleria Negrini

31. Data filed (Month, Day, Year) MAY 3 0 2000

32. Registrar's Signatura

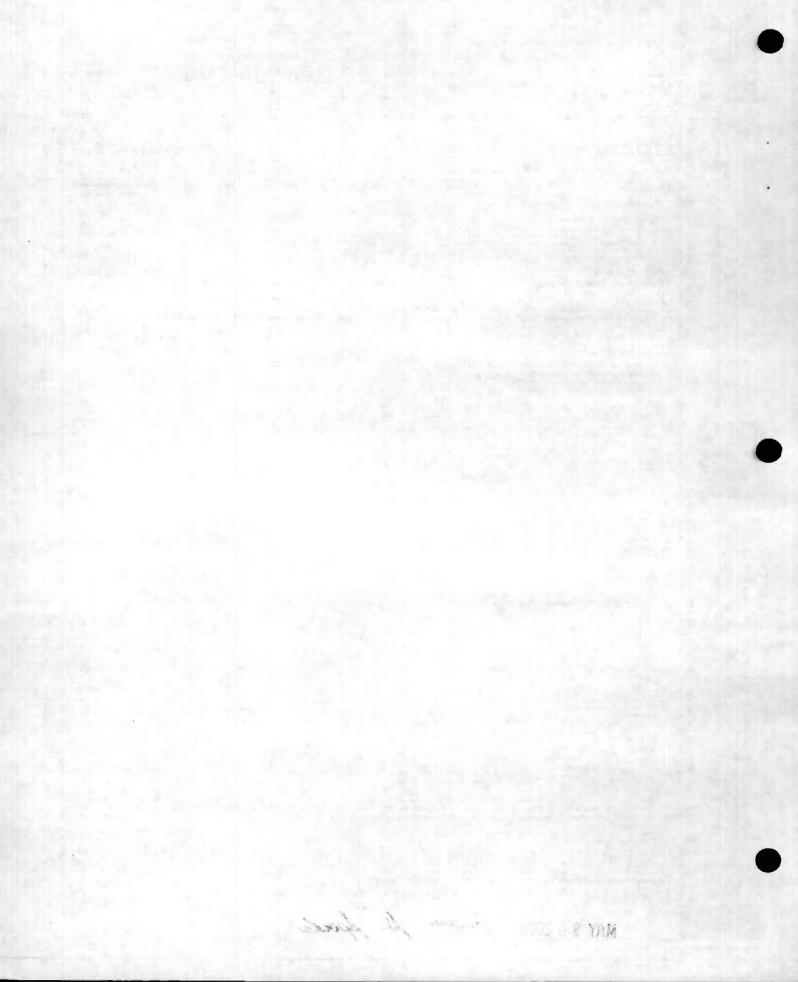
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State of Maryland / Department of Health and Mental Hygiene 70

	Decedent's Name (First, Middle, La.	et)	Certificat	C OI DCUIII	2. Date of Death	. No.	3. Time of Death	
Physician	Charles	1. Well	Month May	Dey Ye 23. 20	er area			
/Medical Examiner	4e Facility Neme (If not institution, give BON SECOUT	e street and number)		4b. City, Town, or	Location of Deeth	4c. County of C	-	
uneral irector	5. Social Security Number 2/5-/2-0888 Usual Residence of Decedent	ex 7. Age (In yrs.	Yrs. If Under	1 Year If Undar 24 Hrs Deys Hours Min		(ear) 9/9 M	Birthplece (State or Fore Country)	
ž u	10a. Stele 10b. County	10c. Cif	y, Town or Location			C 10 [1]	10d. Inside City Lim	
be notified by Director	Mary/Ano		Ham 101. Zig		100	. Citizen of Wha	1 Country?	
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al', or hams 23/ Examiner must by Funeral	11. Marital Stalus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Amled Forces? 1 Dayes 2 □ No if Yes, Give Yeer or Detes:	S. 13. Wes Dece If Yes, spe	dent of Hispanic Origin? (Scify Cuben, Mexicen, Puel	Specify Yas or No- rto Rican, etc.)	Black, V	American Indian, White, etc.	
feat feat	15. Decedent's Ed		16e. Decedent's Usu	al Occupation	nting 10	6b. Kind of Busin		
At the Medical	(Specify only highest gra Elementery/Secondary (0-12)	College (1-4or 5+)	Supply	se retired)	G	Greiner, Inc.		
arked otherstic event.	17. Father's Neme (First, Middle, Last, Lloyo B. WEL					e (First, Middle, Maiden Surname) E. Jonason		
a ma	19a. Informant's Neme/Reletionship (Type, Print)		(Street and Number or F				
127 in sec 111	EMMA WGLLS 20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ 4 □ Donetion Dother (Special	/wife		FRANKLIN.				
5558	- July 1 "	23a. Pert . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respondence, or heart failure. List only one cause on each line.						
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ng physician and s as the burial-transit Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	Due to (o	r es a consequence of):	0		28		
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ed by the attend detached for us Physician/	Pert II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Pert I.	23b. Did tob	acco use contri	buta to the cause of de	
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should should					24e. Was en perform		4b. Were autopsy findin availabla prior to completion of cause of death?	
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this cardidate	1 Yes 2 No		ER/Outpatient 3□ D	OA Other: 4 Nursing 28c. Injury et Work?	Home 5□ Resider	ce 6 □Othar (Specify)	
After ti funera funera	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28d. Describe how	28d. Describe how injury occurred			
an Director: After the led in by the funeral Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specif			ion (Street and Number or Rural Route Number, or Town, State)			
within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certificat		ysician: To the best of my kno niner: On the besis of examine and manner stated.						
To the	295 Signature and title of certifier	. 1	(n	c. License number	29	d. Date signed (Month, Day, Year)	
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N	30 Name and address of person who	10 21223						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MARJORIE Year **Physician** WHITESELL 01:20 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALDMORE BARMORE CITY OF MARYLAND MIVERS IM If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Months DEC. 11,1926 MASSACHUSETTS Director 033-14-8048 73 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limifs I Hygene other than "natural", or frame 23s or 28s-f show went, the Medical Examiner must be notified at Yes 2 No Director MARYLAND N/A BALTIMORE 10f Zin Code 10g. Citizen of What Country? 10e Street and Number Funeral 2825 LODGE FARM ROAD, APT. 301

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? U.S.A. 4. Race - American Indian, Black, White, etc. 21219 Was Decedent of Hispanic Origin? (Spacify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Saltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important. If hew 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SANDERS GEORGE EMMA DUCHARME 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 295 TOLNA ROAD, SHREWSBURY, PENNSYLVANIA MR. KENDALL W. WHITESELL (SON) 17361 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 5/31/2000 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) GLEN HAVEN MEMORIAL PARK GLEN BURNIE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 21. Signature of Funeral Service Licenses Par MU234 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final Cancer una disease or condition resulting in death) Examiner Examine the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last Due to (or as a consequence of): and Box 68760. physician The law requires that the death certificate be Physician/Medical Due to (or as a consequence of) BS. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ate has been signed by page 2 should be detact 1 ☐ Yse 2 ☐ No 3 ☐ Probably 4 ☐ Onknown heral Vascular disease þ 24b. Were autopsy tindings available prior fo completion of cause of death? 24e. Wes an autopsy performed? Completed certificate hes 1 Tes 1 ☐ Yes 2 ☐ No septal or Attending Physician: Thours after death.
Ineral Director: After this certificate filled in by the funeral director, pa 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) 1□ Yes 2万No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

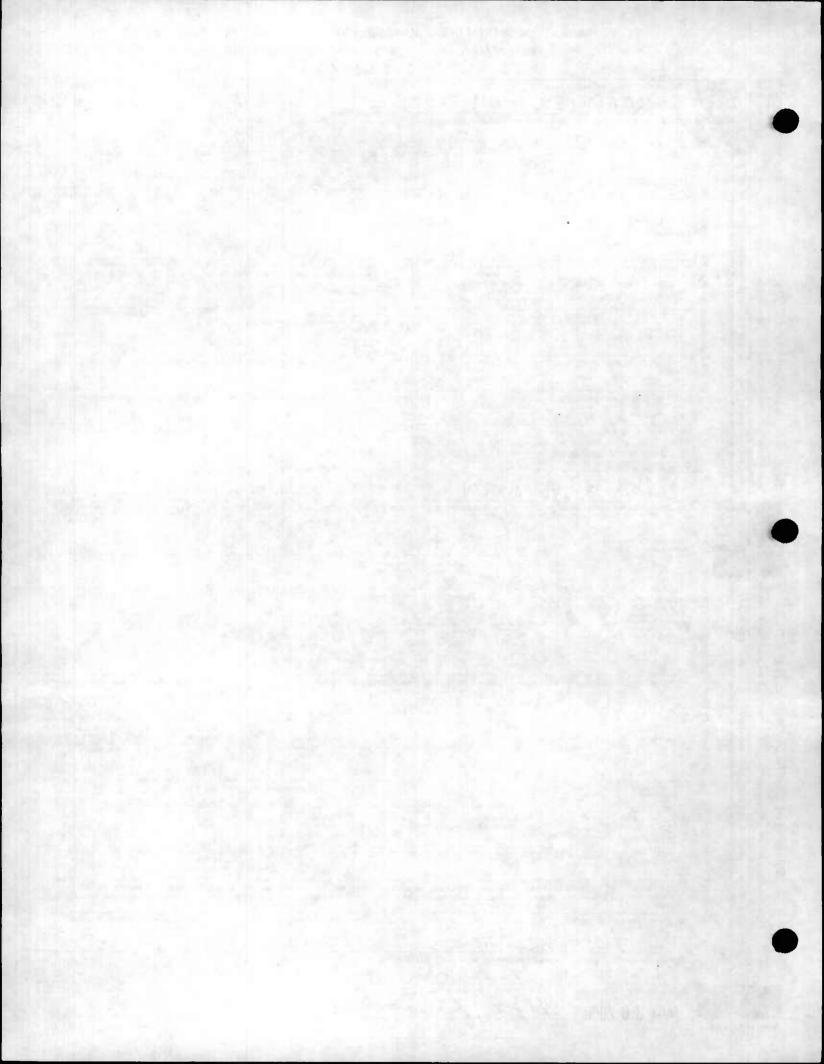
To the Funeral C

completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 27, 2000 P12454 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LISA NIPKOW 22 South Greene Street Balhmore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State works Registrar MAY 3 0 2000

ORIGINAL

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible., State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year DAVID H. WELSH 5:25 PM 2000 MA 24 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HOSPITAL, 10 N. GREENE ST BALTIMORE, MD N/A VETERANS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 177-10-9757 7. Age (In yrs. last birthday) 1X M 2□ F Days Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland White Marsh 1 ☐ Yes 2 No 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5629 Allender Road 21162 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver/ Mechanic Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ira Welsh Unknown 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Henderson/ Companion 5629 Allender Road, White Marsh, MD 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc 5/26/00 Beltsville, MD CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr. Baltimore, MD 21. Signature of Funeral Service Licensee 21286 23a. PartT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) METABOLIC ACIDOSIS DAYS Due to (or as a consequence of): MUDROME EPATORENAL 3 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): > I MONTI INCER OF UNKNOWN Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 3⊠ Probably 4⊠ Unknown 1 | Yee 2 | No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ≥ Yes 2 □ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1⊠ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 28a. Date of tnjury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene.

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Department of Health ar Important: If item 27 is any injury or other trau

Maryland 21215-0020

Baltimore,

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical Completed by 8

ed by the attending physician and detached for use as the burial-transit To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Certification: To

ata has been signed by t page 2 should be detach this certificate

Medical

Registrar

State

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one)

182 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Rachna Gupta

5 Pending investigation

6 Could not be determined

29c. License number

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

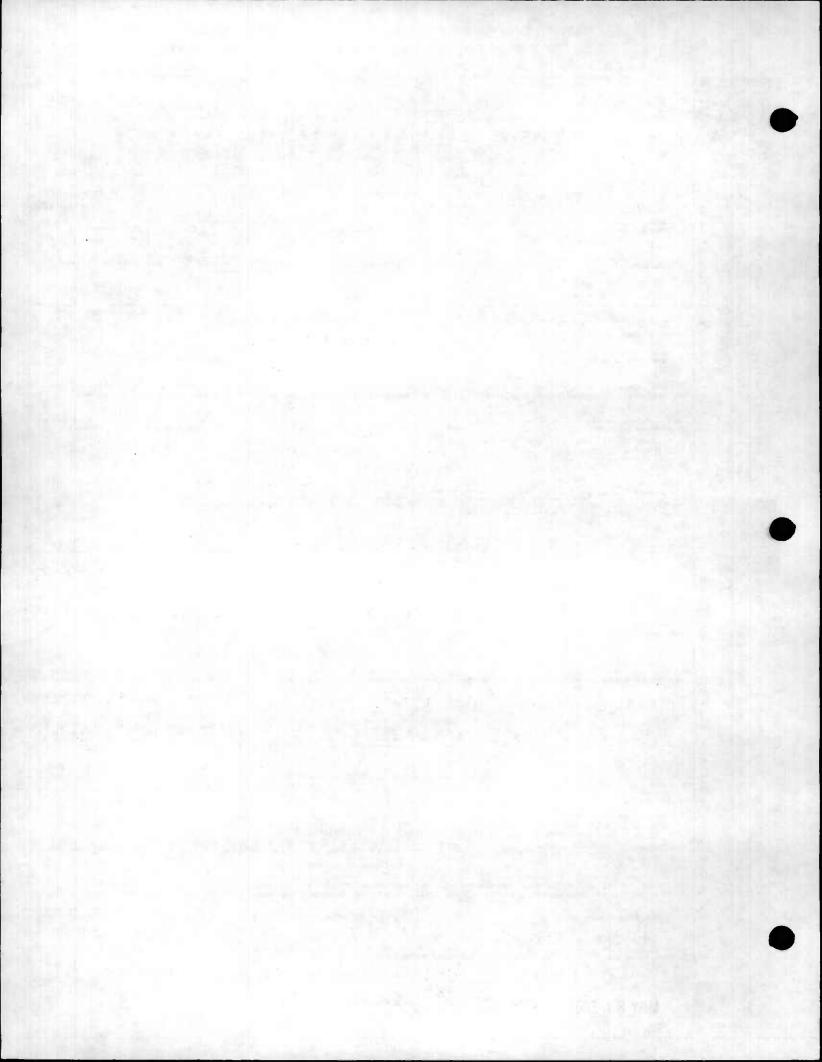
VETERANS HOSPITAL ID N. GREENE ST KACHNA MD

31. Date filed (Month, Day, Year)

MAY 3 0 2000

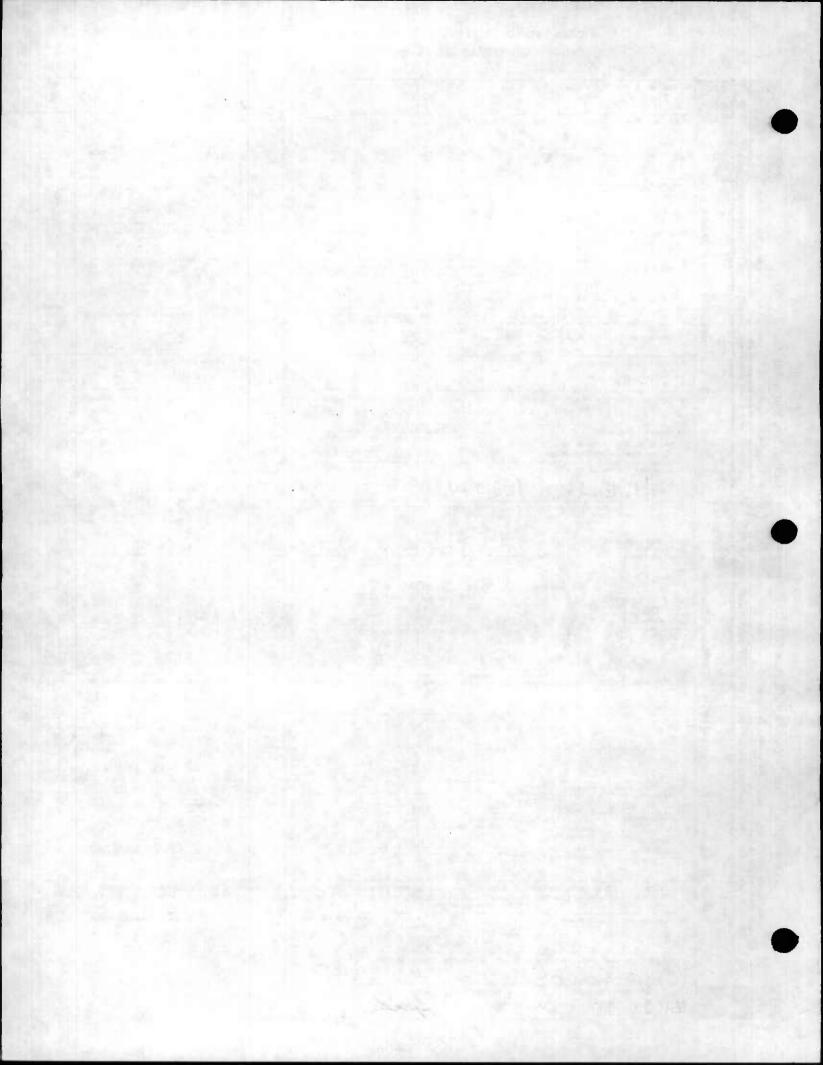
32. Registrar's Signature

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)



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	1. [Decedent's Neme (First, Middle, La	ast)		Certifica		Journ	2. Date of De	Reg. No. ath	3. Time of Death
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eral	5. 5		Sex 7. Age	(In yrs. last b		er 1 Year	If Under 24 Hrs.	8. Date of Bird (Month, Da		irthplace (State or Foreig
ctor		12-92-6966	XQ M 2□ F	63	Yrs. Months	Days	Hours Min.	NOV. 1	5, 1936 KC	DREA
al, or items 23e or 28e-f show Examiner must be nothlise at by Funeral Director	-	ual Residenca of Decedent a. Stete 10b. County		10c. City, Tox	wn or Location					10d. inside City Limit
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		. Street and Number		do	10f. Z	ip Code	ma. Y		10g. Citizen of What 0	Country?
	6	06 PADDLEWHEEL (COURT			2110			U.S.A.	
by Funeral	•	Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:		13. Was Dec If Yes, sp		ispanic Origin? (Sp in, Mexican, Puerto Specity:	ecity Yes or No Rican, etc.)	14. Raca - An Black, Wh Specify: K	
Completed		15. Decedent's E (Specify only highest gra	ducation ade completed)	16	a. Decedent's Us	ual Occup	ation during most of work f)	ing	16b. Kind of Busines	ss/Industry
mpi	E	Elementary/Secondary (0-12)	College (1-4or 5-	+)					220227	
		Father's Name (First, Middle, Last	2	0	WNER/OPE	RATO		a /First Middle	RETAIL F	OOD
Be	1	UNKNOWN)		YI				maiden demandy	/ **********	
5	1	e. Informant's Name/Relationship	(Tuna Print)	10		ss /Straat	(UNKNOW	-	er, City or Town, State	(UNKNOV
		RS. MYUNG SAENG							RSVILLE, M	
	20a	. Method of Disposition		20b. Place	of Disposition (News), crematory or	ame of			20c. Location - City of ELKRIDGE	
		1 Burial 2 Cremation 3 C					RIAL PARK	/31/200	ELKRIDGE,	
ei .	21.	Signatura of Funeral Service King						GLETON	FUNERAL HO	
g		Mylm to	A Moin	34					N BURNIE,	
	23	a. Part1. Enter the disease, or com shock, or heart failure. List only	polications that caused	the death. Do	not enter the mo	ode of dyin	ig, such as cardlec	or respiratory a	rrest,	Approximate Interval Between
I Examiner	dis	mediate Cause (Final isase or condition sulting In death) quentially list conditions, introduced to the conditions of t	b. Ponta	t hem	Arm Syma a consequence of a consequence of	,.				
edical	ELIS	at initiated events sulting in death) Last	d	Due to (or as a	consequenca of):				
		1000								
	Pan	t II. Other eignificant conditions of	contributing to death bu	t not resulting	in the underlying	cause giv	en in Part I.	23b. Did	tobacco use contribu	Ite to the cause of deat
clan/M	Par	til. Other eignificant conditions of	contributing to death bu	t not resulting	in the underlying	cause giv	en in Part I.			
by Physician/M		t II. Other eignificant conditions	contributing to death bu	t not resulting	in the underlying	cause giv	en in Part I.	1 ☐	Yes 2 10 3 1	Probably 4 Unknown
Physician/M		t II. Other eignificant conditions	contributing to death bu	nt not resulting	in the underlying	cause giv	en in Part I.	1 ☐	Yes 2 No 3 □ an autopsy med? 24	b. Were autopsy finding available prior to completion of cause
Be Completed by Physician/M		Was case referred to medical examiner?		nt not resulting	in the underlying		26. Place of Deet	1	Yes 2☐No 3☐ an autopsy	Probably 4 Unknown b. Were autopsy finding available prior to completion of cause of death?
To Be Completed by Physician/M	25.	Was case referred to medical examiner?	Hospital: 1 🗹 Inpatie	nt 20ER/C	Dutpatient 3□ [OOA Oth	26. Place of Deel	24e. Was park	an autopsy 24l Yes 2 No 3 Yes 2 No one)	Probably 4 Unknown. b. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No
To Be Completed by Physician/M	25.	Was case referred to medical examiner? I yes 20 No Manner of Death Natural 5 Pending	Hospital: 1 Inpatier 28a. Dete of Injur	nt 20ER/C	Outpatient 3□ [DOA Oth	26. Place of Deel er: 4□ Nursing Ho y at k?	24e. Was park	an autopsy 24l Yes 2 2 No	Probably 4 Unknown. b. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No
To Be Completed by Physician/M	25.	Was case referred to medical examiner? 1 Yes 2 No Manne of Death	Hospital: 1 Inpatier 28a. Dete of Injur (Month, Day)	nt 2 ER/C	Outpatient 3 [] [Time of Injury M	DOA Oth	26. Place of Deel	24e. Was park	an autopsy 24l Yes 2 No 3 Yes 2 No one)	Probably 4 Unknown. b. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No
Certification: To Be Completed by Physician/M	25.	Was case referred to medical examiner? Yes 2 No Manner of Death 1 Notural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide 1 Notural 1	Hospital: 28a. Dete of Injur (Month, Day) on 28e. Placa of Injur building, etc.	nt 2□ER/C y Year) 28b iry - At home, (Specify)	Dutpatient 3 0 1. Time of Injury M farm, street, factor	DOA Oth 28c. Injur Wor 1 □	26. Place of Deel er: 4 ☐ Nursing Ho y at k? Yes 2 ☐ No	24e. Was parto	an autopsy 24l med? Yes 2 No 3 Yes 2 No 2 N	D. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No
Certification: To Be Completed by Physician/M	25.	Was case referred to medical examiner? 1 Ves 2 No Manner of Death 1 Natural 5 Pending investigation investigation determined 4 Homicide 6 Could not determined a. Certifier 1 Certifying Pi	Hospital: 28a. Dete of injur (Month, Day) 28e. Placa of Injur building, etc. hyelcian: To the bast of miner: On the basis of	nt 2 ER/C y Year) 28b sry - At home, . (Specify) f my knowledgexamination a	Outpatient 3 [[[[[[[.	28c. Injur Wor 1 Dory, office	26. Place of Deel ier: 4 □ Nursing Ho y at k? Yes 2 □ No	24e. Was part of the Check only of the Check onl	an autopsy 24l yes 2 2 No 2ne) denca 8 Other (S) how injury occurred Street and Number or wn, State)	b. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No Pacify) Rural Route Number,
To Be Completed by Physician/M	25.	Was case referred to medical examiner? 1	Hospital: 28a. Dete of Injur (Month, Day building, etc.) 28e. Placa of Injur building, etc.	nt 2 ER/C y Year) 28b sry - At home, . (Specify) f my knowledgexamination a	Outpatient 3 [1] Time of Injury M farm, street, factors, deeth occurrer, and/or investigation.	28c. Injur Wor 1 Dory, offica d at the tiron, In my c	26. Place of Deel eer: 4 Nursing Ho y at k? Yes 2 No me, date and placa, pinion, deeth occur	24e. Was part of the Check only of the Check onl	an autopsy 241 med? 241 med 251	D. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No Pecify) Rural Route Number, es atated, five to the ceuse(s)
edical Certification: To Be Completed by Physician/M	25.	Was case referred to medical examiner? I yes 20 No Manner of Death 1 Natural 5 Pending investigatic 3 Suicide 6 Could not to determine determine (Check only one)	Hospital: 28a. Dete of injur (Month, Day) 28e. Placa of Injur building, etc. hyelcian: To the bast of miner: On the basis of	nt 2 ER/C Year) 28b Iry - At home, (Specify) If my knowleds examination a	Outpatient 3 [1] Time of Injury M farm, street, factors, deeth occurrer, and/or investigation.	28c. Injur Wor 1 Dory, offica d at the tiron, In my c	26. Place of Deel eer: 4 Nursing Ho y at k? Yes 2 No me, date and placa, pinion, deeth occur	24e. Was part of the Check only of the Check onl	an autopsy 241 med? 241 med 251	D. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No Pecify) Rural Route Number, es atated, five to the ceuse(s)
edical Certification: To Be Completed by Physician/M	25. 27. 29t	Was case referred to medical examiner? I yes 20 No Manner of Death 1 Natural 5 Pending investigatic 3 Suicide 6 Could not to determine determine (Check only one)	Hospital: 28a. Dete of injur (Month, Day) 28e. Placa of Injur building, etc. hyelcian: To the best of and menner sta	ont 2 ER/C y Year) 28b stry - At home, . (Specify) f my knowledgexamination ated.	Outpatient 3 [[Time of Injury M farm, street, factor occurre and/or investigation 2	28c. Injur Wor 1 Dory, offica d at the tiron, In my c	26. Place of Deel er: 4 Nursing Ho y at k? Yes 2 No	24e. Was part of the Check only of the Check onl	an autopsy 241 an autopsy 241 Yes 2 No 2000 One) denca 8 Other (S) how injury occurred Street and Number or wn, State) ceuse(s) end manner dete end pleca, end co	Probably 4 Unkn b. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No Decify) Rural Route Number, es atated. fue to the ceuse(s)



				Certificate of			eg. No.				
Physician	1. Decedent's Name (First, Middle, Las			1 10410	ĺ	Date of Deat Month	Pay Pay	Year	3. Time of Death		
/Medical	REBECCA	ELIZA	BETH	+ ARMS		MAY	1	000	~ IOPM		
Examiner	4a Facility Name (If not institution, give				4b. City, Town, or Loc	ation of Death	4c. County	of Death			
	5898 Morning Bi			Malada d Vana	Columbia			vard			
ral or	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						n. (Month, Day, Year) Coun				
	Usual Residence of Decedent				1 1	arch 14	+, 1920	Mar	yland		
	10a. State 10b. County 10c. City, Town or Location 10d. In:										
0	Maryland Howard			Columbia					1 Yes 2 No		
Funeral Director	10e. Street and Number		-		10g. Citizen of What Countr						
i	5898 Morning Bi	rd Lane		2104	5		USA				
	11. Marital Status	12. Wes Decedent	Ever in U.S.			cify Yes or No-		- America	an Indien,		
	1 Never Married 2 Married 3 🕅 Widowed 4 Divorced	No	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No		o Rican, etc.) Bleck, White, etc. Specify: Black						
ŀ	15. Decedent's Ed	ucation	16a.	Decedent's Usual Occu	pation		16b. Kind of Bu	Business/Industry			
-	(Specify only highest gra-	de completed)		(Give kind of work done life. DO NOT use retire	during most of working)	g					
	Elementary/Secondary (0-12)	College (1-4or 5	,+)	Domestic		7-	Someone	Else	e's Home		
ŀ	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, I	Maiden Sumam	9)			
	George L.	Bı	cown		Mary		Ty1	er			
-	19e. Informant's Name/Reletionship (7			Mailing Address (Street	- J	Route Number	- 7		Code)		
	James Diggs/Son			06 Arabella							
r	20a. Method of Disposition			Disposition (Name of y, cremetory or other pla			20c. Location -				
	14 Buriat 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify			Church Cen		13/00	Hunting	town	MD		
-	21. Signeture of Funeral Service Licen		Louinga	22. Neme end Addre				-	110		
	bhles.	1			22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678						
_	Journal a	sewell						TCK,	100000		
	23a. Part1. Enter the disease, or comp shock, or heart laiture. List only	one cause on each li	the death. Do n ne.	ot enter the mode of dy	ing, such as cardiac of	respiretory err	est,	- 1	Approximate Intervel Between Onset and Death		
									Onset and Doutt		
	Immediate Cause (Finel disease or condition resulting in death)	a Ather	osdero	tic Coroni	ary Arte	ery 12	isease	1	Tears		
			Due to (or as a c	consequence of):	,						
		b. Hyper	rteusi	on					years		
	Sequentially list conditions, if any, leading to immediate		Due to (or as a c	onsequence of):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
	resulting in death) Last		Due to (or as a c	onsequence of):				i			
	d										
				9 31				1			
1	Part II. Other significant conditions co	ontributing to death b	ut not resulting in	the underlying cause gi	ven in Part I.	23b. Did tobacco use contribute to the cause of death					
	GERD COPE					1 Yes 2 No 3 robably 4			ably 4 Unknow		
	0010										
						24a. Wes e perfor		eve	ore autopsy lindings pilable prior to		
,						19-0		of d	npletion of cause deeth?		
						1 🗆 Y	es 21XNo	1	Yes 20 No		
-	25. Was case referred to medical				26. Place of Deeth (Check only one)						
	examiner?	Hospital: 1 Inpatie	nt 2 ER/Out	tpatient 3 DOA Ot	her: 4 Nursing Hon	ne 5 A Reside	ence 6 Othe	or (Specify)		
	27. Manner of Death	28a. Dete of Inju (Month, Da)					ow injury occurr		CE-LEW T		
	1 Neturet 5 Pending investigation		, , , , , , , , , , , , , , , , , , , ,		Yes 2 □ No						
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of Injudicing, etc	ury - At home, lei	m, street, fectory, office	2	8f. Location (SI City or Town	cation (Street and Number or Rural Route Number,				
	- I HORMOUG	F - 15	Only or TOWN	., UIUIU/							
	29a. Certifier (Check only 25 Medical Exam	reician: To the best of iner: On the basis of end manner sta	examinetion and	deeth occurred et the ti	ime, date and place, e opinion, deeth occurre	nd due to the co	ause(s) and me ate end pleca, e	nner es sta and due to	ated. the cause(s)		
	270. Signature and the of certified		7	29c. Licen	se number	2	9d. Date signed	(Month, E	Day, Year)		
	1		Lip	N3	1473	467					
	Trongens	11	10 N	. (0	1473		May 1	015	2000		
	30. Name end address of person who o	1	1	1 1 0	12	1. 16	. (4.	n -			
	PATRYCE A. TOYE	, MD 45	65 Hen	clock Cone	way E	licott C	ity M	1) 2	1012		
		on Destre			1						
	31. Date filed (Month, Day, Year) MAY 1 2 2000	he see a see	ar's Signature	las it.							

DHMH 16 Rev 6/95

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Certificate of Death 1. Decedant's Name (First, Middle, Last) 2, Dete of Deeth 3. Time of Death Month Yaar **Physician** George Wesley Ashley 7:38AM May 8, 2000 /Medical 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly if Under 24 Hrs. 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Months Hours M 2□ F 78 Yre Director 578-40-3212 June 12, 1921 Jamaica Usual Residence of Decedent with the Meryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location Nem 27 is marked other than "natural", or hams 23s or 25s-4 show other traumatic event, the Medical Examinar must be notified at Prince George's 1X Yes 2 No Chapel Oaks Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1418 Farmingdale Avenue 20743 USA deeth Funeral 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Rece - American Indian. Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If them 27 is merked other than "natural", or has any injury or other traumatic event. 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married **Black** 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bureau of Engraving & Supervisory Chemist 4yrs. Printing 18. Mothar's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Hurbert Ashley Ruth Bennett 10 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) April Ashley/ Wife Chapel Oaks, MD 1418 Farmingdale Ave. 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removet from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Memorial Park 5-13-00 Suitland, Maryland 22. Name end Address of Fecility Marshall's Funeral Home of MD 21. Signature of Funerel Service Licenses 4308 Suitland Rd. Suitland, MD 23a. Per1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediete Ceuse (Finel disaase or condition resulting In death) /Medical Examiner Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest physician end s the buriel-tran The law requires that the deeth certificate be execu P.O. Box 68760. Physician/Medicai Due to (or es a consequence of 85 ettending for ed by the e Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by t 1 Yas 2 No 3 Probably 4 Doknown Records, þ 24b. Were autopsy findings avelleble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy peed hes page 2 1 □ Yes 1 □ Yas certificate Division of Vital Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica director, Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Inpatient 2 BOA funeral 27. Manner of Death 28c. Injury et Work? Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation Injun 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) completely To the Vithin 2 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) DR. MEERA KANHOUWA P.G. Hospital 3001 Hospital DR. Cheverly, MD

DHMH 16 Ray 6/95

State Registrar 31. Dete filed (Month, Dey, Yeer) MAY 1 2000

3. Registrer's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2000 Mary Hendricks Atkins May 11:10 A.M /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Collington Life Care Nursing Home Mitchellville 8. Date of Birth (Month, Day, Year) A119. 15, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1□M 20 F Yrs. 90 225 42 3058

Funeral Director

Usual Residence of Decedent

10e. Street and Number 37 Church Street

1 ☐ Never Married XIX Married

3 ☐ Widowed 4 ☐ Divorced

Elementery/Secondary (0-12)

12

10b. County

Isle of Wight

15. Decedent's Education (Specify only highest grade completed)

4

10a State

Virginia

11. Marital Status

Directo

Funeral

the Medical Examiner must be notified 288-1 items 23s or hours after 8

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be that within 72 it. Department of Health and Mental Hygiene. Important: If them 27 is marked other then nettainly for other transmitted other then nettain.

> Physicián /Medical Examiner

The law requires that the death certificate be executed pue the or Attending Physician: funerel

Box 68760,

P.0.

Division of Vital Records,

To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun State Registrar

Completed 17. Father's Neme (First, Middle, Last) Charles Hendricks 19e. Informent's Name/Relationship (Type, Print) Jean A. Nouri Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Windsor Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that clused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause of mich line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Due to (or as a consequenca of): Examiner (ERE BROVASCULAR Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequenca of): ARTENOSCLEMOSIS Physician/Medical Due to (or as a consequence of): ITY PER TONSION Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. ATRIAL FIBRILLATION ģ Medicai Certification: To Be Completed CORONARY ARTERY DISEASE BREAST CANCER 25. Was case referred to medical examiner? Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 1 Neturef 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

1909 Alton Virginia 10c. City, Town or Location 10d. Inside City Limits XX Yas 2 No Windsor 10g. Citizen of What Country? 10f. Zip Code 23487 United States 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 20 No Specify: White Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Teacher Public School Systems 18. Mother's Name (First, Middle, Maiden Surname) Hallie (Unavailable) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13502 Gullivers Tr. Bowie Maryland 20720 20b. Placa of Disposition (Name of cemetery, crematory or other place) May 12, 2000 20c. Location - City or Town, State Windsor, Virginia 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 Approximate Interval Between Onset and Death 72 ItOURS DISEASE BOYEARS 40 YEARS

40 YEARS

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

20 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, State)

1 Yes

D46834

29d. Date signed (Month, Dey, Year) 5-8-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYRUH M WOPEZ MO

7525 GROBNWAM CENTER DR. SUITE 113

31. Dete filed (Month, Day, Year) MAY 1 0 2000 2. Régistrar's Signeture

Timbul E. E. y. Co

Source of the source of the source

the Maryland permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylai Depertment of Health and Mental Hydiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumstic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

The lew requires that the deeth certificate be executed physician end s the burial-transit Box 68760. 98 ettending p ed by the e signed b Division of Vital Records, peen : hes certificate : After this certifice e funeral director, Attending Physician: ual or Ah.

VI Director; Ah.

In by th 24 hours effer Funeral Dire letely filled In b To the Hosp within 24 hos To the Fune

9226 EDWARDS WAY #1103 5. Social Security Number 578-14-7851 Usual Residence of Decedent 10a. Sfate MARYLAND PRINCE GEORGES Directo 10e. Street and Number Funeral 11. Marifei Status 1 Never Married 2 Married 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) N/A 17. Father's Neme (First, Middle, Last) CHARLES ALLEN PEARL ALLEN 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) ARLENE K. WASHINGTON/ 11 SCHUBERT CT., SILVER SPRING, MD 20904 20b Place of Disposition (Name of 20c. Location - City or Town, Stete Date 20a. Method of Disposition MARYLAND NAT. CEMETERY MAY 11, 2000 LAUREL, MARYLAND 1 Deurial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signefure of Funeral-Service La 22 Name and Address of Fecility
DUDLEY FUNERAL HOME MT. RAINIER, MD 20712 EDWARD M. DUDLEY 3200 RHODE ISLAND AVE., 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. Approximete Interval Between Onset end Death Immediate Cause (Finel myo Landia disease or condition resulting in deeth) Examiner Artenisclesofic Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of) Physician/Medicai that initiated events resulting in death) Last Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Was an autopsy Ped performed' Complet 1 Yes 20 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending 1 Naturel 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 00

700 BUCKINGHAM DRIVE, SILVER SPRING, MARYLAND

State Registrar 30. Name and addre

31. Date filed (Month, Day, Year)

union who completed cause of death (Item 23a) (Type, Print)

37 Registrar's Signature

M.D.,

LEE,

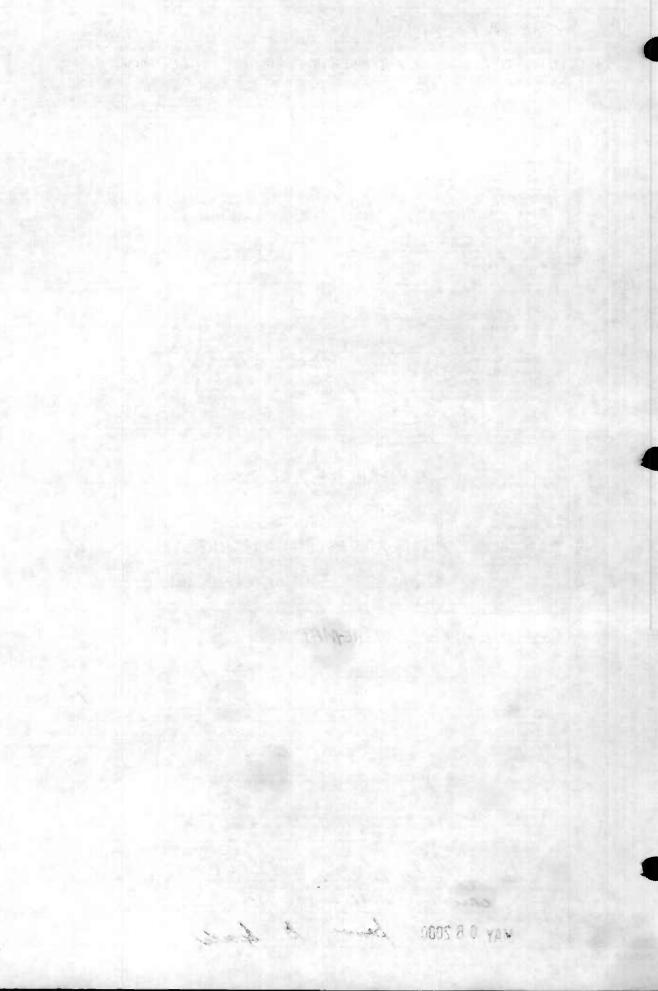
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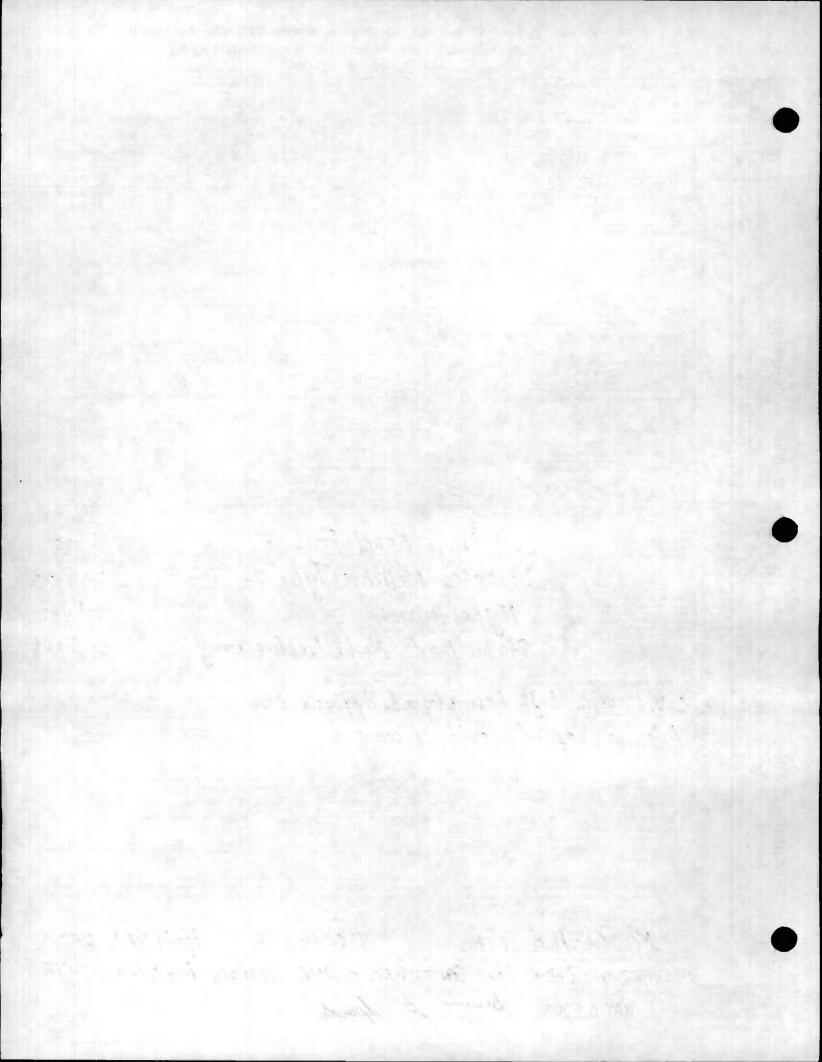
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 7 0 2 8

					Ce	rtificate of	Death		Reg. No.			
Physician	1. Decedent's Name (First, Middle, Last) Mary Bridges 4a Facility Nema (If not institution, give street and number) Deer's Head Center							2. Data of De Month	Day	Year	3. Tima of Deeth	
/Medical							4b. City, Town, or		28, 2000		10:15 AM	
Examiner							Salisbu			omic		
uneral	5. Social Security N				yrs. last birthday)	If Under 1 Yaar	If Undar 24 Hrs	•			placa (Stata or Foreign ntry)	
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tor tor	MD	Wicon	nico		Salisbur	v					1∭ Yes 2□No	
be notified Director	10e. Street and Nu				Dazzosa	10f. Zip Coda			10g. Citizen of	What Cou	ntry?	
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r tema 234 riner must Funeral	11. Marital Sfatus		12. Was Dac Armed Fe	edenf Ever	in U,S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No			can Indian,	
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27 la r trau	Neola	Waller	(Cousin)		P.0.	Box 1646	, Salisb	ury, MD	21802			
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2 8	one) 29b. Signatura and	title of certifie		nnar stated.		29c. Licans	sa number		29d Date sign	ed (Month	Day Year)	
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Tot	30. Neme and addr	rass of person	who complated cau	sa of death	(Item 23a) (Type,	Print)	ME SAI	ich or Du	MIJ 9	(8'') (8no	2000	

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Daath Month Yaar **Physician** 2000 EARL FRANKLIN /Medical 4a Fscllity Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors' Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months 82 224-03-7900 Director Oct. 1917 Virginia Usual Rasidance of Decedent death with the Maryland 10a. Stata 10c. City, Town or Location Show 10b. County 10d. Insida City Limits event, the Medical Examiner must be notified at 1 X Yas 2 □ No Maryland Prince George's Seat Pleasant **Funeral Director** 288-1 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 23a or 922 Booker Drive 20743 U.S.A. fleme 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Raca - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Health end Mentel Hygiene. important: If them 27 is marked other than "natural", or ther any injury or other traumatic even. 1 ⊠ Yas 2 □ No If Yas, Giva 1 ☐ Nevar Marriad 2 ☑ Married 1 ☐ Yas 2 ☒ No Specify: Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Steam Engineer Private 12th Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Charlie Butler Louise White 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 4001 92nd Avenue, Springdale, Maryland 20774 ca of Disposition (Name of Date 20c. Location - City or Town, State Ronald Anderson/Son Baltimore, 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 05/11 1 2 Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Maryland Veterans Ceme. Cheltenham, Maryland 2000 21. Signature of Forumal Service Licensee 22. Nama and Address of Facility J.B. JENKINS FÜNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat end Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical 1 1-12 DSIJ Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaase or injury that initiated events rasulting in daath) Last use as the bunal-tren and Due to (or as a consequence of): P.O. Box 68760, attending physicien Dua fo (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? t⊠ Yee 2□ No 3□ Probably 4□ Unknown Records, by 24b. Wera autopsy findings availabla prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy performed' certificate has 1□ Yes 2⊠No 1 ☐ Yas 2 ☐ No of Vital Hospital or Attending Physician: Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Medical Certification: To 1 ☐ Yas 2 ☑ No 1 Inpatiant 2 ER/Outpatient 3 DOA s after death.

I Director: After this of in by the funeral d 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending invasfigation 1 SNatural 1 Yas 2 No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 6 Could not ba determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 I Homicida 24 hours 15 Certifying Physician: To the best of my knowledge, deeth occurred et tha time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the To the To the 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and til 5-5-2000 LN124, BOCIEMDZE HO causa of death (Itam 23a) (Type, Rrint) AN 31. Data filed (Month, Day, Year) Registrar's Signatura State 1 2 2000 Registrar

MAY ICENS Janes A. Acres

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month 8,2000 DAVID BERNARD Year 10:30pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Nov 3,1953 6. Sex 1 → M 2 □ F Birthplace (State or Foreign Country)
Liheria 5. Social Security Number 7. Age (In yrs. last birthday) Days Yrs. 46 218-82-9571 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits P.G Hyatteville 1 Yes 2 No M D. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 U.S.A. 8101 Ouentin Street 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 2years Stock Clerk Private 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gomah Dolo Y Dolo 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8101 Quentin St., Hyattsville, Md. 20784 Elizabeth P, Bernard/Wife 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 5/20/00 Gate Of Heaven Cem Silver Spring, Md. 22. Name and Address of Facility 21. Signature of Funerel Service Licens Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash D.C 20011 23e. Pafi1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one eduse on each line. Approximete Interval Between Onset and Death Immediete Cause (Finel Colon Cancer With diseese or condition resulting In deeth) Pay Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceusa (Diseese or Injury that Initieted events resulting in death) Last Due to (or es a consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 00 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25 No 2 No 1 Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

that the death certificate be executed

Box 68760.

P.O.

Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

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238

natural, or items

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite eny Injury or other treumatic event, tre Medical Examine Boce.

Baltimore, Maryland 21215-0020

Examiner must be notified at

Director

Funeral

by

Completed

Be

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Examiner attending physician and for use as the burial-tran Physician/Medical by the a signed by the

certificate Division of Vitai Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical etely filled in by the funeral director. g Medicai To the Hosp within 24 ho To the Fune completely fi

State Registrar

p Completed Be 25. Wes casa referred to medical examiner? Hospitef: 1 Inpatient 1 Yes 2 No Certification: To 27. Menger of Death 28a. Dete of Injury (Month, Day Year) 5 Pending investigation 1 Netural
2 Accident 6 Could not be determined 3 Sulcida 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier

(Check only

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier lev/Inand, M.D.

29c. License number

1 Yes 2 No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Nama and address of person who completed cause of death (ftem 23a) (Type, Print)

Sareer Anand. M.D. 7343 A Hanover Parkway Greenbelt Maryland 31. Date filed (Month, Dey, Year) 32 Registrar's Signature

MAY 1 2 2000

2 ER/Outpatient 3 DOA

28b. Time of Injury

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Year Month **Physician** Pablo Bustillo 05 07 2000 10:53 am /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring, Md. Montgomery 6. Sex 1 AM 2 F If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Yes None 80 Director 08-17-19 El Salvador Usual Residence of Decedent with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County ir than "natural", or flema 23a or 28a-f ahow the Medical Examiner must be notified at D. C. Washington Yas 2 No Director 10e. Street and Number 1630 Park Road, N. W. 10f. Zip Code 10g. Citizen of What Country? # 401 20010 El Salvador Funeral death Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after Hygiene. other than "natural", or its 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 No Yes 2 No Specify: Hispanic ۾ 3 ☐ Widowed 4 🔀 Divorced El Salvadoran Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Self-Employed 6th Farmer pemit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other: any injury or other traumatic avant, II 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Juan Martines Maria Bustillo 2 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 1630 Park Rd., N.W. #401 Washington, D.C. 20010 Ana Romelia Chavez 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State 2000 Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) La Union, El Salvador 22. Name and Address of Facility
W. H. BACON FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 6036 3447 14th St., N.W. Washington, D.C. 20010 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final one day disease or condition resulting in death) Acute Myocardial Infarction ⊥x. in r Due to (or as a consequence of): years Examiner Coronary Atherosclerosis physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): 88 attending p 23b. Did tobacco use contributa to the cause of death? detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by d be detacl 1 Yes PO No 3 Probably 4 Unknown Division of Vital Records, ģ 24b. Were autopsy findings aveileble prior to should Completed 24a. Was an autopsy performed? been a completion of cause of death? After this certificate has KKNO 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 10 1 Yes 2 No 1X Inpatient 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending P a after death. I Director: After t of in by the funers 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signeture and little of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D005568 05-08-2000 20 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Samuel B. Itscoitz 10313 Georgia Ave., Suite 306 Silver Spring, Md. 20902 31. Date filed (Month, Dey, Year) 32. Registrar's Signature MAY 1 0 2000 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible: 7032

	Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death							3. Tima of Death	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Edith	Bell				Month May	Day 200		
xaminer	4a Facility Name (If not Institution, give s Howard County Gene		4b. City, Town, or L Columbia		4c. County of D Howard	eeth			
uneral rector	5. Social Security Number 6. Sax 232 01 5805	м ½ F 7. Age (In yrs. I	last birthdey) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Houra Min.	8. Date of Bird (Month, De August	1h, Year) 9. 27, 1914	Birthplace (State or Fore Country) West Virgi	
1	Usual Residence of Decedent 10a. Stata 10b. County	10c. City	y, Town or Lo	cation				10d. Insida City Lin	
r 28a-f show incursed at	West Virginia Harr	rison C	larksb	urg				1%□Yes 2□	
or 28a-f	10e. Street and Number			10f. Zip Code			10g. Citizen of When	Country?	
23a c	508 Wilson Street			2630	1		United St	ates	
at, or terms receiver m by Funer	11. Marital Stetus 1 1 Never Married 2 Married 3X Widowed 4 Divorced	2. Was Decedent Evar in U,: Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H 1 Yes, specify Cubo 1 ☐ Yes 2501No	tispentc Origin? (Sj en, Mexican, Puert Specify:	pecify Yas or No Rican, etc.)	Black, V	wherloen Indien, White, etc. White	
"natural", adical Em	15. Decedent's Educ	15. Decedent's Education (Specify only highest grade completed)			pation during most of work	kina	16b. Kind of Busine	ess/Industry	
	Elementery/Secondary (0-12)	College (1-4or 5+)			during most of world)		0 11		
vant, tra vant	Unknown U1 17. Father's Name (First, Middle, Last)	nknown	Homem	aker	18 Mother's Nam	a /First Middle	Own Ho	ome	
c avant	William F. Wilson						ekins Wils	son	
them 27 is marked other than other traumatic avant, the 17 of the Comp	19a. informent's Name/Relationship (Typ	pe, Print)			and Number or Ru	ral Route Numb	er, City or Town, Sta	te, Zip Code)	
am 27 is other trau	David Bell	Son					a Maryland		
Important: If ham 27 is any injury or other tra once.	20e. Method of Disposition ***\Suriel 2 \subseteq Cremation 3 \subseteq R: 4 \subseteq Donation 5 \subseteq Other (Specify)	emoval from State	emetery, crer		May 5,		20c. Location - City Quiet De		
Imports any inju	21. Signature of Funaral Sarvice License	arksbur	rksburg WV 26301						
	23a. Part1. Enter the disease, or complice shock, or heert feilure. List only on	errest,	Approximate Interval Between						
ysician ledical aminer	Immediate Ceuse (Final diseese or condition resulting in deeth)	SUBARA	A CH		Math	DRRHI	AGE	Onset end Deat	
n and ial-transit	_ b								
a pr	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated eventa Due to (or as a consequence of):								
_ 0	resulting in death) Last		r as a conseq	derice ory.					
d for	Part II. Other significant conditions con-	tributing to death but not rasu	ulting in the u	nderfying cause gir	van in Part I.	23b. Dld	tobacco use contril	outs to the cause of de	
igned by the attending be detached for use a by Physician/M	CHRONIC LY		OCYTIC LENKEWIA				1 Yee 2 No 3 Probably 4		
should should						24a. Was perfo	4a. Was an autopsy performed? 24b. Were eutopavailable p completion of death?		
page 2						10	Yes 2 No	1 □ Yes a□ No	
rector, pag	25. Was case referred to medical examiner?	/			26. Place of Dec	th (Check only	one)		
Pis Pis	1 Yea 2 H	/· · · · · · · · · · · · · · · · · · ·	ER/Outpatier	IL SEL DOA			idence 6 Other	Specify)	
After t funera tlon:	27. Manner of Death Flatural 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	Wo	ry et rk? Yes 2 □ No	∠ou. Describe	how injury occurred		
ector: by the	2 Accident 3 Suicide 4 Homicide A Homicide	28e. Plece of Injury - At he building, etc. (Specify	ome, ferm, str		2010	28f. Location (City or To	. (Street end Number or Rurel Route Number, own, Stete)		
o the Funeral Dir empletely filled in Medical Cert		ician: To the best of my knower: On the basis of examinal end manner stated.							
To the comple	29b. Signature prompte of certifier	raure	- M	0 29c icen	Se number US		29d. Date signed (A	fonth, Dey, Year)	
/	30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type,	Print) NAP	ous 1	20	ELLICUR	ruty 21	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	itura						

DHMH 16 Rev 6/95

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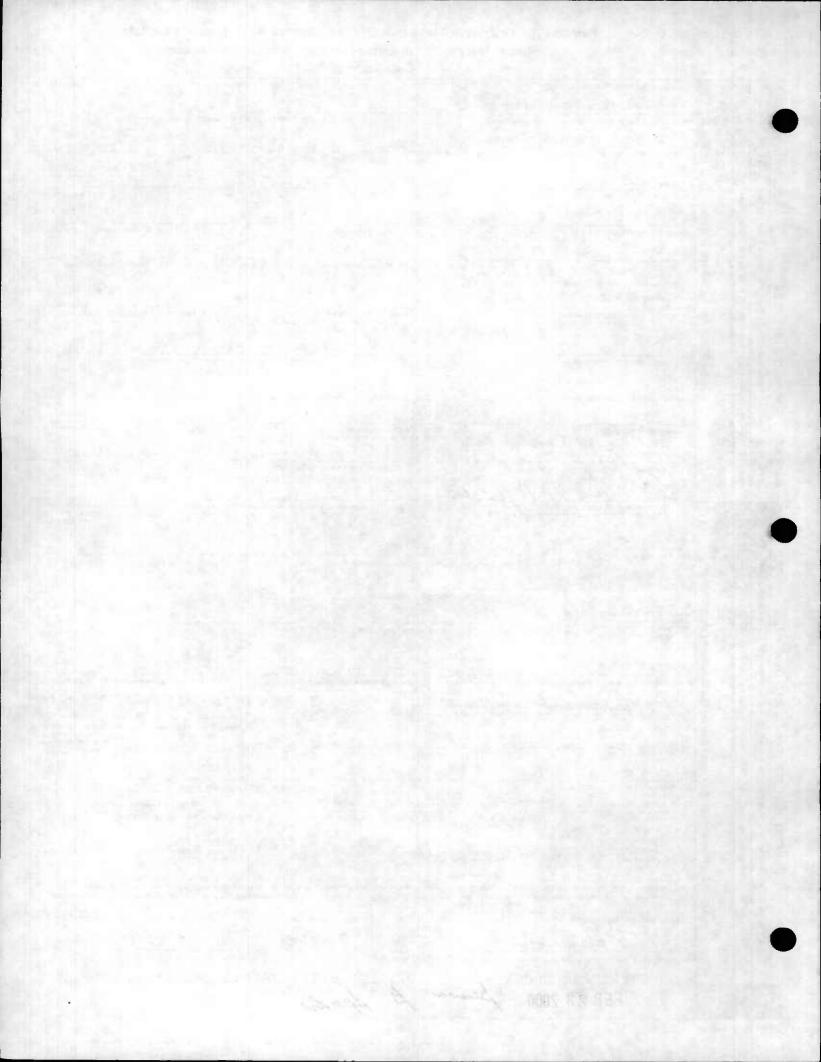
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Day **Physician** Feb. 15, 2000 Adelaide Martha Conway 2:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 20994 Old School Street Wicomico Bivalve Hours Min. 8. Date of Birth (Month, Day, Year)

July 28, 19 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2XF Months 78 Maryland Director 213-24-4564 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County "natural", or items 23s or 26s-f show MD Wicomico Bivalve 1X Yes 2 No Director the Medical Examiner must be notify 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20994 Old School Street 21814 U.S.A. Funeral paintil. Papes 1 and 2 should be filed within 72 hours after deal important. If Health and Mental Hygiene, any Injury or other traumatic event. 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: **Black** Specify à 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nanticoke Seafood Seafood Industry 18. Mother's Neme (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Be Iva Gaines Charles Quinton 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Valarie Williams 301 Highland Avenue, Delmar, MD 21875 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 2/19/00 Jesterville, MD Jesterville Cemetary 21. Signature of Funeral Service Lice 22. Name and Address of Facility Messick Funeral Home, P.O. Box 61 Bivalve, MD 21814 23a. Part1. Enter the disease, or complications hat ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the bunal-transit Sequentially fist conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical Due to (or es a consequence of) P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ∳ Unknown Dracase arkensons Division of Vital Records. à 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate has 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No or Attanding Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 2 1 Yes 20 No 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural aftar death.
Director: Aft 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined To the Hospital or Atla within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D29105 12000 truento 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) Christian Huddleston, M.D., 106 Milford St., Salisbury, Md 31. Date filed (Month, Day, FEB 23 32. Reostrar's Signature State 2000

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year Evelyn Μ. Cogle May 4. 2000 1:10 AM 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Potomac Valley Nursing & Wellness Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 10-10-1913 9. Birthplece (State or Foreign Country)
Washington, D.C. 6. Sex 7. Age (In yrs. last birthday) Months Days 1□ M 21XF Yrs. 86 577-26-0825 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Prince George's Landover Hills 10e. Street and Number 10g. Citizen of What Country? 6722 Darby Road 20784 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White 3€ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles Edward Hammer Josephine Dailey 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Fladung / Daughter 6722 Darby Road Landover Hills, Md. 20784 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete t⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-6-2000 Brentwood Maryland Fort Lincoln Cemetery Signeture of Funeral Service Lice 22. Neme end Address of Fecility Fort Lincoln Funeral Home ellasels 3401 Bladensburg Road, Brentwood, Maryland 20722 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) . Coronary Artery Disease Due to (or as a consequence of): Hypertensive Heart Disease Due to (or es a consequence of): Congestive Heart Failure Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

physician and s the burial-transit

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After

Unders after death.

Undersi Director: After ally filled in by the fun

To the Hospital or within 24 hours aft To the Funeral Dis completaly filled in

director,

The law requires that the death certificate be executed

Box 68760

P.O. |

Records,

Division of Vitai or Attending Physician: Examiner

Physician/Medical

þ

Completed

8

Certification: To

Medical

Physician

/Medical

Examiner

Director

Funeral

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10a. State

Funeral

Director

is 1 and 2 should be filed within 72 hours after death with the Manylan of Health and Mental hyghen. The files 23 or 28s-1 show other traumstic avent, the Health Examines must be notified as other traumstic avent, the Health Examines must be notified as

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is merked oths any Injury or other traumatic avant, page.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24b. Were autopsy tindings available prior to 24a. Was an eutopsy performed? completion of cause of death?

29d Date signed (Month, Dey, Year)

5-4-2000

1 Yes 2 No

1 Yes 2 No 25. Wes case referred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1☐ Yes 2☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

29b. Signature and title of certifier

t☐ Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) and menner es stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the ceuse(s) and manner stated.

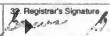
29c. License number

D47330

Jamas Joseph 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50W. Edmonston Dr. #207 Rockville, MD 20852 Thomas V. Joseph, M.D.

State Registrar 31. Date filed (Month, Day, Year) MAY 1 1 2000



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Chucci 10:30 PM Antonia MAY 2000 6 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Southern Maryland Hospital Clinton If Under 24 Hrs. If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F 86 Yrs 214 07 4272 Director June 30, 1913 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits P.G. MD 1 Yes 2 No Director Capital Heights Nems 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 3905 Clark Street permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiane. Important: If item 27 is merked other than "natural", or fierna 23a and highery or other traumatic event, the Medical Examinar muses bods. United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ENo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Merital Status 1 ☐ Never Married 2 ☐ Merried 21215-0020 1 Yes 2 No Specify Be Completed by White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Personel Clerk Saltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annam Dimartino Vitus Altobello 19a. Informant's Name/Relationship (Type, Print)
Michaelina Chucci / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3905 Clark Street, Capital Heights, MD 20743 20b. Place of Disposition (Name of cemetery, cremetery or other place) May 17 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Arlington, Virginia Arlington National Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical week. Examiner Examiner Attending Physician: The law requires that the death certificate be executed for use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical weak Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 3 TONO ate has been signed by page 2 should be detac 3 Probably 4 Unknown Aq 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed Cougestive 24a. Wes en eutopsy performed? Chronic Anemia 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical B 26. Place of Deeth (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

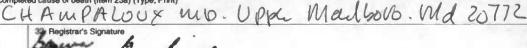
Registrar

31. Date filed (Month, Day, Year) MAY 0 9 2000

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



lecupale

29c. License number

D42049

29d. Date signed (Month, Dey, Year)

MAY 0 3 2000 Sware & Line

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Charles J. Davis 14, 2000 May 2015 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown 23809 McIntosh Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) Mar. 7, 190 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** Days 218-01-5082 94 Yrs 1906 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or Items 23a or 23a-f show idical Examiner must be notified at 1 Yas 2 No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 23809 McIntosh Road 20650 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bteck, White, etc. 11. Marital Status It and Mortal Hygiene.
7 is marked other than "natural", or item treumatic event, the Medical Examiner. 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: Black 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: á 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygilimportanti if then 27 is marked other any Injury or other trauments office. 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be John Davis Macie Sewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) Charles F. Davis/Son P.O. Box 538 California, MD 20619 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1X Burial 2 Cremation 3 Removal from Stata Our Lady's Chapel Cem. 5/19/00 Medley's Neck, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service License 22. Nama and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 Sewell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsat and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? detached been signed by the should be detached 1 Yea 25 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy findings svaileble prior to complation of cause of deeth? Completed 24a. Wes an autopsy performed? page 2 s 1 Yas 25 No 1 ☐ Yas 2 ☐ No cartificate Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funaral director; p. Be 25. Was casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home ST Rasidence 6 Othar (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yas 2 No Certification: To 27. Manner of De 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Matural 5 Pending investigation 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide *© Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only 29b. Signature a title of certifie 29c. License number 29d. Data signed (Month, Day, Year) 5.16.00 DO1380 30. Nama and address of person who completed cause of seath (Item 23a) (Type, Print) Leonardtown, MD 20650 John F. Fenwick, M.D. 31. Data filed (Month, Day, Year) 32. Registrags Signature State MAY 16 2000 Registrar

AVAILED SOLLED IN JONES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Year Irene Virginia Dashiell 8 2000 1:55A.M. MAY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth SALISBURY If Under 24 Hrs. 8. De WICOMICO WICOMICO NURSING HOME If Linder 1 Year Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months Hours 10 M 20 F Yrs. 72 Feb. 12, 1928 221-18-5716 Virginia Usual Residence of Deceden 10a. State 10c. City, Town or Location 10b. Counts 10d. Inside City Limits 1⊠ Yes 2 No Maryland Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 518 Winder Street 21801 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 NWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer 7th seasonal 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Smith Henry Viola McBride 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Fountain/caretaker/friend 7603 Kowen Avenue - Salisbury, Maryland 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 XBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memcry Gardens 5/11/00 | Hebron, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Furieral Service Licens Jolley Memorial Chapel 21801 23a. Pert1. Enter the disease, or complications shock, or heart feilure. List only one cause Approximete Intervel Between Onset end Deeth mode of dying, such as cerdiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last dierosellerobe ours cal Due to (or as a consequence of): th but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? contributing to de 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 258 No 1□Yes 25€No rees 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

Box 68760 Records, P.O. Division of Vital

Examiner physicien and se the buriel-transit signed by t peen Certification: To this To the Hospital or Attanding Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera After t

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2 Accident

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Director

item 27 is marked other than "natural", or forms 23s or 28s4 show other treumade event, the Medical Examinar must be notified at

and Mental Hygiene.

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Physician /Medical

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Pages 1 and 2 should be nent of Health and Mental

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6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide TEI Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 5-8-2000

1 Yes 2 No

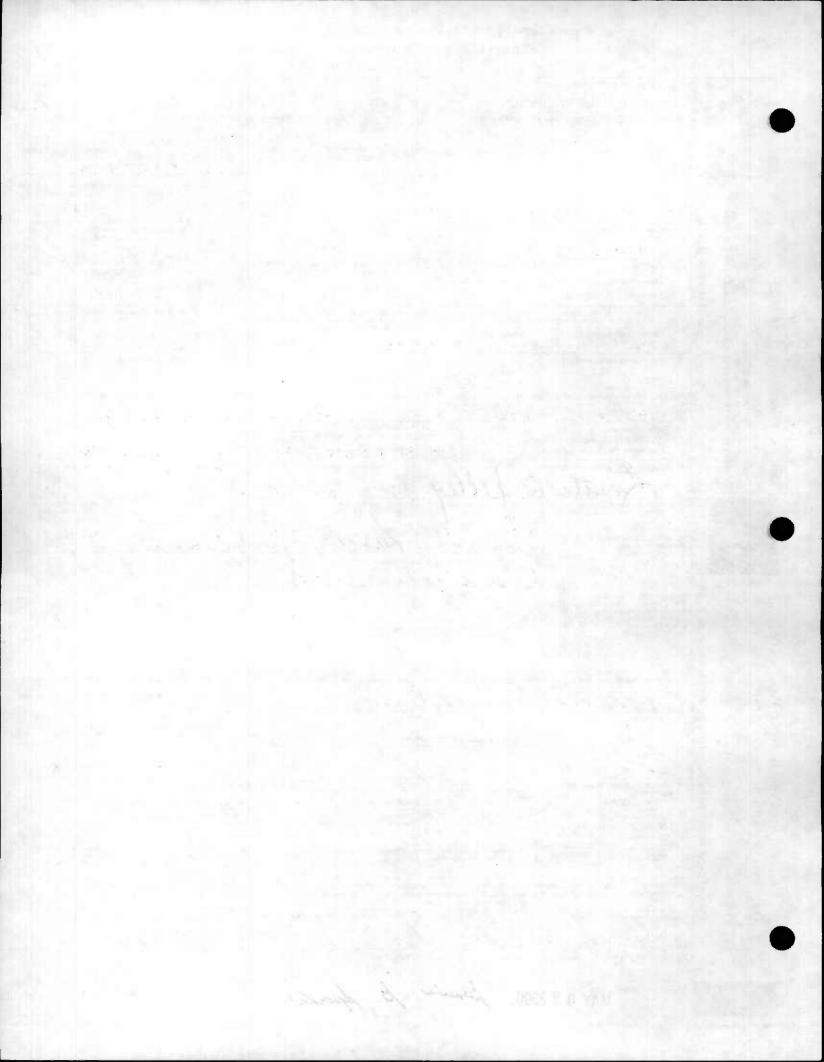
Name and podress of person who completed cause of death (Item 23a) (Type, Print)

9 2000

5 Pending investigation

GREGORIO BELLOSO, MD 5302 CHINABERRY DRIVE SALISBURY MD 21801 31. Date filed (Month, Day, Year) MAY 0 32. Registar's Signature

Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Dyer Physician 07:47 Paul Mai 2000 08 /Medical 4s Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Beath 4c. County of Death **Examiner** ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL

7 Age (In virs. last birthday) If Under 1 Year | If Under 24 Hrs. MONTGOMERY 8. Data of Birth (Month, Day, Year) SEPT. 7, 1919 Birthplace (Stata or Foreign Country) 5. Social Security Number **Funeral** Days 1⊠M 2□ F Months Hours Yrs. 510-16-7007 80 Director KANSAS Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2K No Directo 28a-1s MARYLAND WICOMICO SALISBURY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 3 U.S.A. Funeral 21804 203 FRANCIS DR. 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or ther any Injury or other traumatic event, the Medical Example. 1 X Yas 2 No WWII If Yas, Giva Yaar or Datas: ARMY 1 Nevar Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elamentary/Secondary (0-12) 12 HORTICULTURALIST U.S. GOVERNMENT 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) CHARLES EUGENE DYER, SR. ELIZABETH THURSTON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) PAULA L. DYER - DAUGHTER 12 SCANDIA WAY ROCKVILLE, MD 20850 altimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 Burial 2 □ Cramation 3 □ Ramoval from Stata SPRINGHILL MEMORY GARDEN\$ 5/11/00 4 ☐ Donation 5 ☐ Othar (Specify) HEBRON, MARYLAND 22. Name and Address of Facility 21. Signature of Fuperal Sarvice Licensea 705 E. MAIN ST. SALISBURY, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician Immediate Causa (Final disaasa or condition rasulting in death) Aspiration Pneumonia /Medical Examiner Examiner Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated avants resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobecco use contribute to the cause of death? Infection 1 Yes 2 No 3 Probably 4 DOnknown Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 200 No 1 Yas 2 No 1 Yes is or Attending Physicien: The ster death.

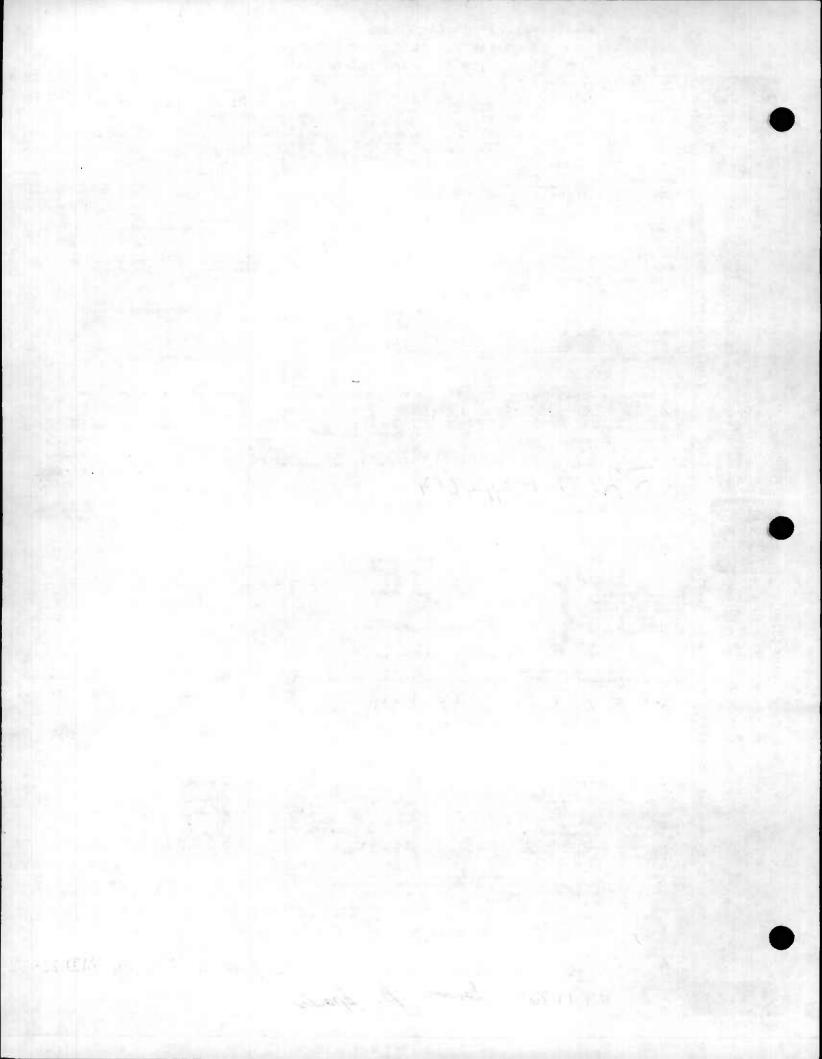
In Director: After this certificate of in by the funeral director, pa 25. Was casa rafarred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 Watural 1 Yes 2 No 2 Accidant 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be datarmined 3 Suicida To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. Medical 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signatura and titla of certifian illie MA D53244 May 8, 2000 5+IVA SIC 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

DHMH 16 Rev 6/95

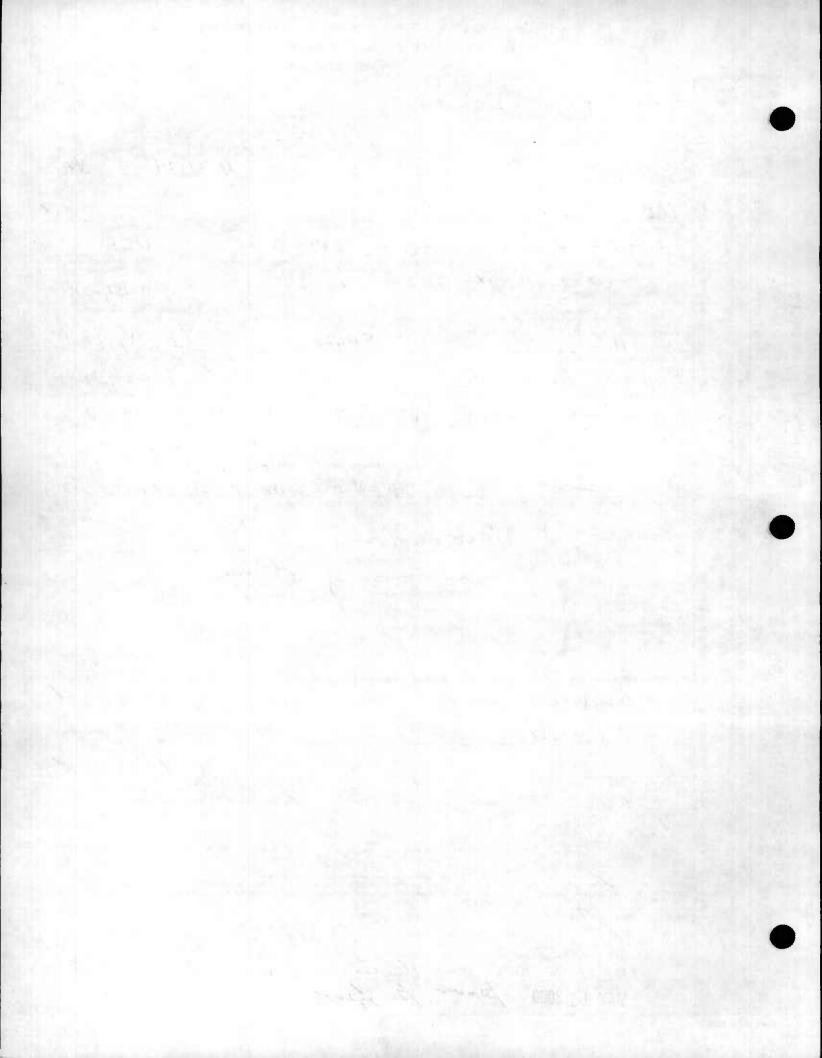
32. Registrar's Signature

MAY 1 0 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17039

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 9, May 2000 Antoinette N. DeChard 6:00 PM 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth 932 Ship's Bell Court Anne Arundel Annapolis Hours Min. 8. Date of Birth (Month, Dey, Yeer)
Feb. 23, 1923 If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. lest birthday) 6 Sex Deys 1□M 2₩F Months 77 Yrs. 578-32-9282 Kansas Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 932 Ship's Bell Court 21401 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, 11. Meritel Stetus Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Yaer or Detes: 3€ Widowed 4 Divorced White Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specity only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Film Librarian Library 18. Mother's Neme (First, Middle, Meiden Sumema) 17. Fether's Neme (First, Middle, Last) Leon Blanchard Marquerite Anderson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 932 Ship's Bell Court Annapolis, MD 21401 Audrey R. DeChard/sister-in-law 20e. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete Metropolitan Crematory 5/11/00 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funarei Sarvice Licensaa 22. Name and Address of Fecility Cocar Hill Funeral Home, Inc. Cheathan Upularomey 4111 Pennsylvania Ave. Suitland, Md 20746 Pert 1. Enter the diseasa, of complications that ceused tha deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, of heart failure. List only one cause on each line. Approximata Interval Between Onset end Deeth 23a /Pert 1. Immediate Ceuse (Finel disease or condition resulting in death) ue to (or as a consequence of): Can Due to (oy a consequence of) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacgo-use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy 1 Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any lojury or other traumatic event, Bize,

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Registrar

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) end menner steted. 29b. Signeture end title of certifiar

28e. Place of Injury - Al home, ferm, street, factory, office building, etc. (Specify)

29c. License number 153306

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

600 Ridgely Avenue Annapolis mo 2140 30. Name and eddress of person way completed cause of daeth (Item 23a) (Type, Print)

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32 Registrer's Signeture 1 2 2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death :51 di 4c. County of Death Steven Thomas Dinges 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Doctor's Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 220-48-8045 48 May 27, 1951 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Counts 1 X Yes 2 □ No Maryland | Prince George's Riverdale 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5405 55th Place 20737 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Merital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Computer Operator NASA 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David W. Dinges Mary E. Holden 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. fnformant's Name/Reletionship (Type, Print) Mary E. Dinges - Mother 5405 55th Place, Riverdale, Maryland 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 5/10/2000 4 □ Donation 5 □ Other (Specify) Brentwood, Maryland 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Casch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final diseese or condition resulting in death) traema Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of):

Physician /Medical Examiner

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Examiner Physician/Medicai | 2 þ Completed Be

the death certificate be axecuted P.O. Box 68760. Division of Vital Records. To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral

edicai Certification: To State Registrar

DHMH 16 Rev 6/95

30. Name and address of person who

MAY 1 0 2000

ause. Enter Underlying ause (Disease or injury nat initiated events esulting in death) Lest	cDue to (o	r as a consequenca o	of):	148	
art It. Other significant conditions co			g cause given in Part t.	23b. Did tobacco use co	antribute to the causs of death?
				24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
5. Was case referred to medical			26. Place of De	eth (Check only one)	
examiner?	Hospital: 12 Inpatient 2	ER/Outpatient 3	Other:	Home 5 ☐ Residence 8 ☐ Oth	ner (Specify)
7. Manner of Death Neturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occur	red
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fac y)	tory, offica	28f. Location (Street and Number City or Town, Stete)	ber or Rural Route Number,
				a, and due to the cause(s) and m urred et the time, dete end place,	

29c. License number

7560 Hanger Parkway Suite 105 Green bett MD 20170

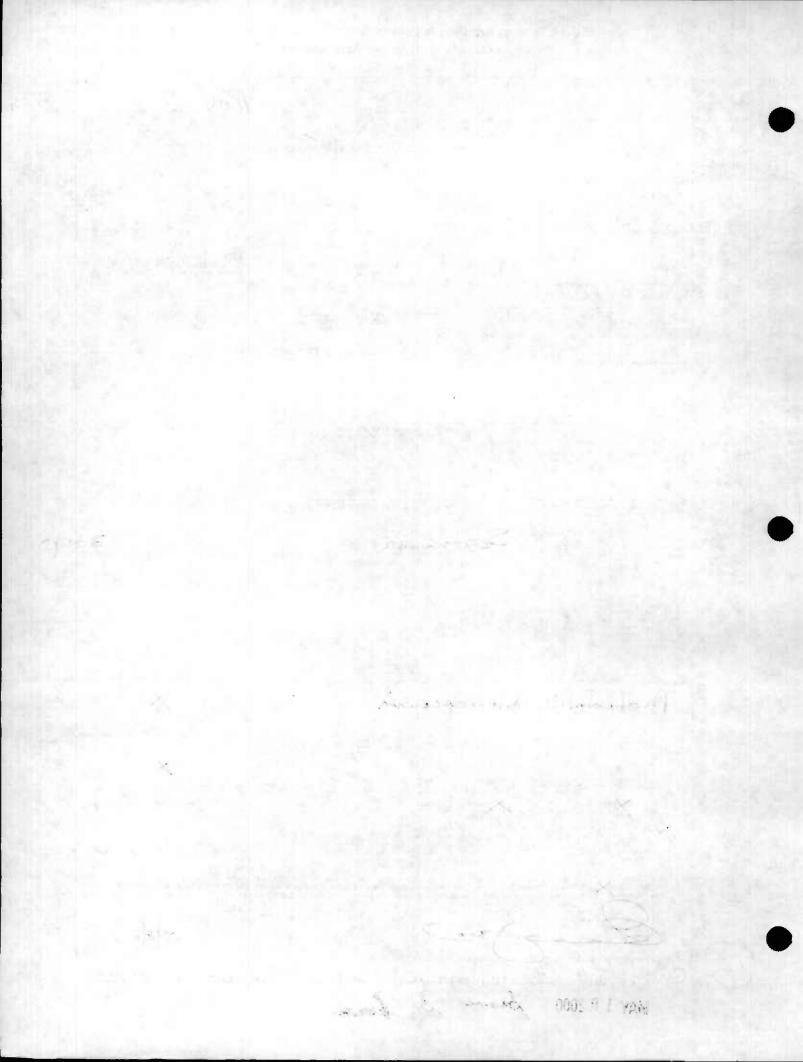
D16410

29d. Date sigged (Month, Dey, Year)

003

ORIGINAL

under se of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	1	U	1:	6.
	1	17	170	1701

1						Ce	rtificate	of	Death		Reg. No.	1 /	046
Physicia		1. Decedent's Nama (Firs	t, Middle, Las	st)		1	200			2. Date of D Month	Dav	Year	Tima of Death
/Medica	al -	Sakhoeun				Dan			4b. City, Town, or I	MAY 0			1:43 AM
Examine	er	4a Facility Name (If not it FT. WASH									1	E GEORG	FS
Funeral		5. Social Security Number	6. S	ex	7. Aga (In yrs.	last birthday)	If Under		Oxon Hil	8. Date of B			(Stata or Foreign
Director	-	230-25-4908 Usuel Residence of Dece		☑M 2□F	46	Yrs.	Months	Days	Hours Min.		22, 195		mbodia
with the Maryland a or 28a-f show Lbe notified at		1 1	rince	George		Oxon							nside City Limits ☐ Yes 2 ☑ No
23a or 21 unit be no	ā	10e. Street and Number 7010 Le	yte	Drive		10f. Zip Code 20745					10g. Citizen of What Country? USA		
hours after dea	by Fur	11. Marital Status 1 Never Married 2 3 Widowed 4 D		12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	2⊠ No ve		Was Decede It Yas, speci 1 ☐ Yas 2		lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Ricen, etc.)	city Yes or No- Ricen, etc.) 14. Race - A Black, V Specify:		ndian,
Maryiding XIXID-0020 12 should be find within 72 hours at h and Mantal Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. D (Specify on: Elementary/Secondary		lucation de completed) Collega (1-4or 5+)	(Give		done retire	pation during most of wor d)	king	16b. Kind of B	usiness/Industr	у
ad with	Con	12				Tax	i Driv	er				rtatio	n
Martal H Martal H rhad off rdic ever	To Be	17. Father's Name (First, Kith Prak	Market Control						Yon Dan		e, <i>Maiden Sum</i> an	10)	
CHNL		19a. Interment's Name/R Saly Som	elationship (i wid				-		an <i>d Number or Ru</i>			State, Zip Cod 20745	fe)
or other		20a. Method of Dispositio 1 ☐ Burlel 2 🖾 Cred	mation 3 🗆		Stete	Place of Dispo cemetery, cre	matory or other	her pla		/13/00	20c. Location		
Gallimore, emit. Pegas 1 a apartment of Her my Injury or othe BGB.	+	4 Donation 5-0		fort-	E		2. Nama and	Addra	Homes Cress of Facility			dria,VA	
a sales		10/2	</td <td>1 -</td> <td>Maj</td> <td>141</td> <td></td> <td></td> <td>neatley E Braddock</td> <td></td> <td></td> <td>.VA 223</td> <td>02</td>	1 -	Maj	141			neatley E Braddock			.VA 223	02
V. 30		23a. Pert1. Enter the distance, or heart fillu	ease, ol com	plications that one cause on o	caused the dea	th. Do not en	ler the mode	ot dyl	ng, such as cardied	or respiretory	arrest,	App	proximete ervel Between
Physician / /Medical Examiner		tmmediate Ceuse (Final disease or condition resulting in death)		a. A	torios	Lew	hic	C	grange	scolor	- Dise	se	set and Daath
P E	ner			b	Due to (or as a conse	quenca ot):					1	
death certificate be executed eathending physician and dor use as the burial-transit	Examiner	Sequentially list condition if any, leading to Immedia cause. Enter Underlying Cause (Disease or Injury	as, ate	0.	Due to (or as a conse	quence ot):			- 4			
rificate be ex ng physician es the burial	g	Cause (Disease or Injury thet initiated events resulting in death) Last	1	С.	Due to (d	or as a consec	quenca ot):		6.27	7.5		1	
	an/M		-	d								1	
	Physician/	Part It. Other significant	conditions of	entributing to d	eath but not res	sulting in the u	inderlying ca	use gi	ven in Part I.		Yes ZNNo		cause of death
s that the	y P	Mobile	25 N	Vill	Jus					1	TARE STALLO	3 Probabi	y 4 Onknow
he lew requires that ehes been signed?	Completed by									24e. We per	s an eutopsy formed?	evailat	eutopsy tindings ele prior to etion of cause h?
he ie he sage 2 age 2	d d									NE	Yes 2 No	100 Ye	
ysician: ysician: is certifica director, p		25. Was cese referred to examiner?	medical	21					26. Place of Dec	oth (Check only	one)		
_ 5 00	2	1 XYes 2 No				ER/Outpatie			4 Li Nursing r	lome 5 □ Re	sidanca 6 DOt	nar (Specify)	a
Attending Pl or death. ector: After th by the funera		27. Manner of Death 1 Natural 5 □ 2 Accident	Pending investigetion		ot tnjury th, Day Year)	28b. Time of Injury	M 28	Sc. Inju Wo 1 □	ryat rk? Yes 2 □ No	28d. Describe	how injury occur	rred	
UIVISION I or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	286. Place	of Injury - At hing, etc. (Speci	oma, farm, st	reet, tactory,	offica			(Street and Num. own, State)	ber or Rural Ro	oute Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical			niner: On the b					me, date and place opinion, deeth occu				
To the within To the compl	Charles	29b. Signature and title o	certifier	la,	(,)		29c.		se number		29d. Date signe		, Year)
(4)		30. Name and address of	person who	completed ceu	se of death (iter			0Q\ 			MAY 08,		
	1	31 Data filed different	العالم الم	LKE 1	CCAN leader Size		Penn S	itre	et, Balt	imore,	Maryland	21201	
State	e	31. Date filed (Month, Da	1 2000	32	lagistrar's Sign	5.							

Registrar DHMH 16 Rev 6/95

00-2450-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JEAN

State of Maryland / Department of Health and Mental Hygiene

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7	U	11	0

Certificate of Death DOYLE 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician Jean E. Dovle MAY 2,2000 1:40P.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BOWIE HEALTH CENTER BOWIE PRINCE GEORGES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yea May 2, 19 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 1□ M 2520 F Months Days Hours 390 48 2727 53 Director Wisconsin Usual Residence of Decedent the Maryland 10a. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show Yes 2 No Prince George's Maryland Bowie Director 10a. Citizen of Whet Country? 10a. Street and Number 10f. Zin Code 6 12114 Foxhill Lane 20715 United States 234 Funeral death Rema : 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? filed within 72 hours after 1 Yes X No If Yes, Give Year or Dates: 1 Never Married & Married 8 21215-0020 1 Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nnt: If Item 27 Ia marked other than ury or other traumatic event, the Mary Eiementery/Secondery (0-12) College (1-4or 5+) Health Care NURSE 12 Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Delbert Goerke Julia Wedel 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kevin F. Doyle Husband 12114 Foxhill Lane Bowie Maryland 20715 20b. Place of Disposition (Name of cemetery, cremetory or other place) May 10, 2000 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriat 2 Cremation 3 Removat from State permit. Page Department of Important: If any Injury or once. Waukesha Wisconsin 4 Donation 5 □ Other (Specify) Joseph's Cemetery 22. Neme and Address of Facility of Funerel Service Licenses Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 Approximate Interval Between Onset and Death Part Enter the disease, or show the control of the plications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, one cause on each line. **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical Examiner Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably (Unknown 6 signed to þ Records. 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy Completed certificate has page Yes 2 No 1 Yes 2 No Division of Vital I or Attanding Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XXYes 2□ No 28c. tnjury at Work? 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation Injury after death.

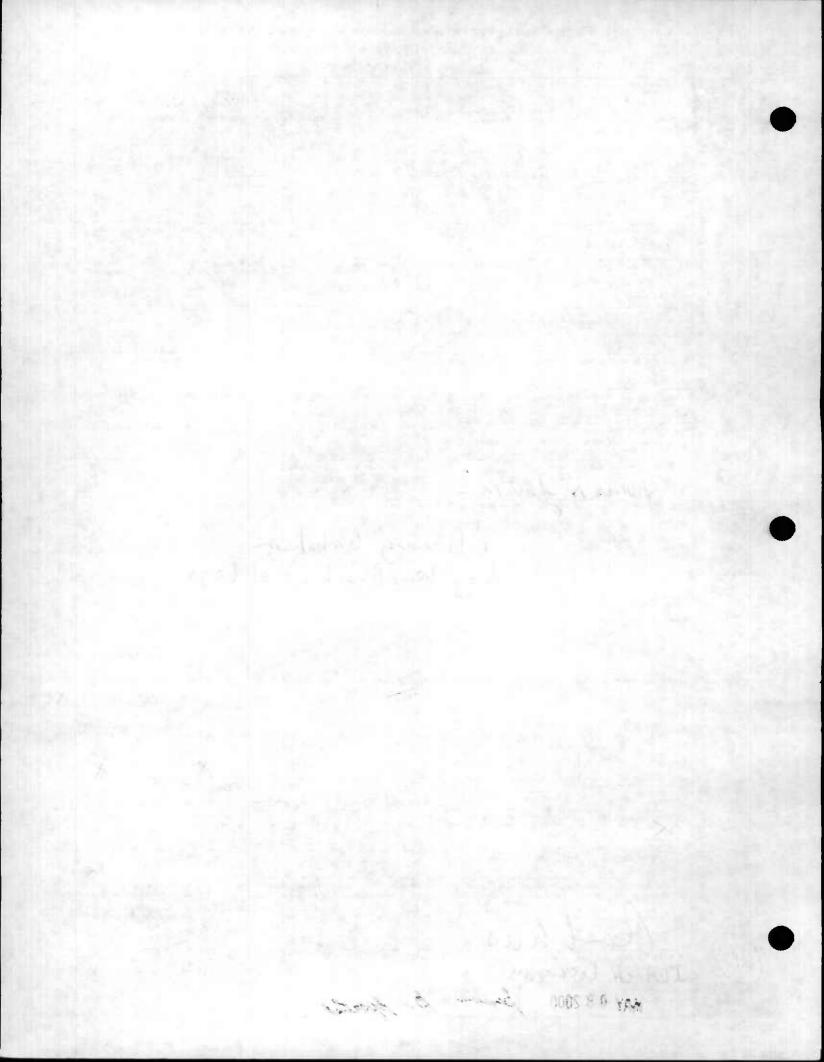
Director: Aft
d in by the fur 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Dey, Year) 29b. Signat 29c. License number O.C.M.E. MAY 3,2000 20 d address of person who completed cause of deeth (Item 23a) (Type, Print) Locke, 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

MAY 0 8 2000 32. Registrar's Signeture

DHMH 16 Rev 6/95

Registrar



DEMISSIE

PETROS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

7066

Physician /Medical **Examiner** 1. Decedent's Name (First, Middle, Last) PETROS DEMISSIE

2. Date of Death MAY

3. Time of Death 4:52P.M.

4a Facility Nama (If not institution, giva street and number) BON SECOURS HOSPITAL

4b. City, Town, or Location of Death BALTIMORE

4c. County of Death

Funeral Director

288-f

23s or

6

filed within 72 hours after

Baltimore, Maryland 21215-0020

231-37-8958 Usual Residence of Decedent 10a. State 10b. Count

10c. City, Town or Location

Yrs.

7. Age (In yrs. last birthday)

8. Date of Birth (Month, Day, Year) SEPT. 9,1936

04.

9. Birthplace (State or Foreign ETHIOP LA

Directo

Funeral

à

Completed

Be

2

FAIRFAX

ALEXANDRIA

10d. inside City Limits 1 Yas XXNo

2000

VIRGINIA 10e Street and Number

6362 MEETING HOUSE WAY

6. Sex 1 M 2 F

10f Zin Code 22312

Months

10g Citizen of What Country? U.S.A.

5. Social Security Number

1 Never Married 2 Merried

12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yas, Give

 Was Decedent of Hispantc Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

If Under 1 Year | If Undar 24 Hrs.

Hours

Days

 Race - American Indian, Black, White, etc. Specify: BLACK

3 ☐ Widowed 4 ☐ Divorced

Yeer or Detes: 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

College (1-4or 5+) 5+

PUBLIC HEALTH DOCTOR

MARYLAND DEPT. OF HEALTH

ALEXANDRIA, VIRGINIA

Approximate Interval Between Onset and Death

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

DEMISSIE

ASKALE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print)

ETSEGENET CHUNI PETROS

6362 MEETING HOUSE WAY ALEXANDRIA, VA

20a. Method of Disposition

Murial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

cematery, cramatory or other place)

20b. Place of Disposition (Name of

20c. Location - City or Town, Stata Date

21. Signature of Funeral S arvice Elcensee

IVY HILL CEMETERY

ATHONOSUMOTE CAMIOVASCUM DIMOSE

MAY 8,2000 22. Name and Address of Facility

DEMAINE FUNERAL HOME 22151 5308 BACKLICK ROAD SPRINGFIELD, VA

Examine

Physician/Medical

P

Completed

Be

page

this

Physician /Medical Examine

physician and the burial-transit

parmit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important; if them 27 is marked oth any injury or other traumatic even alone.

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of)

23a. Part1. Enter the diseasa, or complications that causad the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of): Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Onknown

24a. Was an autopsy performed? TUSPERON

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 3 No

28d. Describe how injury occurred

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yas 2 ☐ No

XXYes 2 No

3 ☐ Suicida

4 Homicide

27. Manner of Death 2 Accident

25. Was case referred to medical examiner?

28a. Date of Injury (Month, Day Year) 5 Pending invastigation 6 Could not be determined 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

0

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and titla of certifian

29c. Licensa number O.C.M.E.

MAY 5, 2000

29d, Date signed (Month, Day, Year)

State

Registrar

Holypuso 31. Date filed (Month, Day, Year) MAY 0 9 2000

160/00/ 32 Registrar's Signature

MM

111 Penn Street, Baltimore, Maryland 21201 portal

DHMH 16 Rev 6/95

Box 68760. P.O. 1 Records, of Vital Division

The law requires that the death certificate be executed

edical Certification: To Attending death. Director: / hours after Hospital or To the Hospital within 24 hours a To the Funeral Completely filled



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No.
Decedent's Name (First, Middle, Last)		2 Date of Death Month Day Year 3. Time of Death
		Month Day Year 9 115Pn
DOCTORS HOSPITAL		
5. Social Security Number 6. Sex 7. Age (In yrs. 217-42-2459 91	last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 14, 1909 9. Birthplace (State or Foreign Country) Washington, DC
Usual Residence of Decedent	v. Town or Leasting	10d. Inside City Limits
		12 Yes 2 □ No
10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3110 Emory Church Rd.	20832	USA
Armed Forces?	,S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
If Yes, Give	1 ☐ Yes 2XXNo Specify:	Specify: WHITE
15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/industry
Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
		Hunter's Lab e (First, Middle, Maiden Surmame)
Henry F. Broadbent		
19a. Informant's Name/Relationship (Type, Print)		
1V Mouriel 2 Commetion 3 Demous from State	cametery, crematory or other place)	Date 20c. Location - City or Town, State
		y 8,2000 Bowle, Md.
90/1/2/55/10		neral Home Inc 16000 Annapolis
23a. Part . Enter the disease, or complications that caused the death	h. Do not enter the mode of dying, such as cardiac	15 or respiratory arrest, Approximate
shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
Immediate Cause (Finat disease or condition ACUTE C	EREBROVASCULAR	ACCIDENT DAYS
Due to (o	or as a consequence of):	
0.		YEARS
Sequentially list conditions, Due to (or if any, leading to Immediate cause. Enter Underlying	or as a consequence of):	
that initiated events	r as a consequenca of):	
d		A Paris Sile
Part II. Other significant conditions contributing to death but not res	uking in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completton of cause
		of death?
OF Was soon salared and		1 Yes 2 No
examiner? Hospital:	Other:	me 5 ☐ Residence 6 ☐ Other (Specify)
27. Manuar of Death 28a. Date of Injury	28b. Time of 28c. Injury at	28d. Describe how injury occurred
2 Accident Investigation	M 1 Yes 2 No	
determined 268. Placa of injury - At no		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a Cartifiar Cartifying Physician: To the best of my kno	where deeth occurred at the time data and place	and due to the cause(s) and manner as stated
29b. Signature and title of certilled	29c. License number	29d. Date signed (Month, Day, Year)
Ketym helich no	022780	5-4.2000
39. Name and address of person who completed cause of death (Item	n 23a) (Type, Print)	annelli Tan a and
31 Date filed (Month Day Year) 32 Bendered's Slove		alteristand rospo
,	pools	
	4a Facility Name (If not Institution, give street and number) DOCTORS HOSPITAL 5. Social Security Number 217-42-2459 1 M 2 S F 91 Usual Residence of Decedent 10a. State 10b. County Md. Montgomery 01 10e. Street and Number 3110 Emory Church Rd. 11. Marital Status 1 Never Married 2 Married 3 Married 1 Never Married 2 Married 3 Married 3 Married 3 Married 3 Married 1 Never Married 2 Married 3 Married 3 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 2 Married 1 Never Married 1 Never Married 2 Married 1 Never Married 1 Never Married 1 Never Married 2 Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Married 1 Never Married 1 N	1. Decedent's Name (Frist, Middle, Last)

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month ^{Day} 2000 **Physician** 13 Hazel Lorraine Edwards May 2:30 PM /Medical 4e Facility Name (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13420 Olivet Road Lusby Calvert | Months Deys Hours Min. June 6 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiaca (State or Foreign Country) 6 1921 Maryland **Funeral** 1 M 2 F 78 Vrs 577 20 5150 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits ehow. 1 Yas 2 No Director Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 13420 Olivet Road 20657 United States Items 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bieck, White, etc. 11. Merital Stetus permit. Pegas 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Item any injury or other treumatic avant, the Medical Exercising DDD. 130 Never Married 2 Merried 1 ☐ Yes 2 ☐ Xgo If Yes, Give Yeer or Detes: 1 Yes 20 No Specify: Specify: White Ď 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Payroll Clerk General Electric Co 17. Fathar's Name (First, Middle, Last) William I. Edwards 18. Mothar's Name (First, Middle, Maiden Sumame) 8 Ella Victoria Lusby 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code) Marie Ireland- sister 13420 Olivet Rd. Lusby, MD 20657 20b. Place of Disposition (Name of May 15 2000 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Buriat 2 Kremation 3 Removel from Stete Alexandria Virginia Metropolitan Funeral Service 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Neme end Address of Fedlity Rausch Funeral Home 20676 4405 Broomes Is. Rd. Port REpublic MD Approximete Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. **Physician** (a40 N Immediate Cause (Finet disease or condition resulting in deeth) /Medical mont Examiner Due to for es a consequenca of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequença of) Physician/Medicai Due to (or es a consequança of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ₩ Yes 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings available prior to completion of cause of deeth? Completed 24e. Was an eutopsy performed? 8 Certification: To

The lew requires that the deeth certificate be executed P.O. Box 68760, physicien s the buria Records, ahould be Division of Vital or Attending Physician: efter death.

Saltimore, Maryland 21215-0020

			1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
25. Wes case referred to medica	al .	26. Piace of Dec	eth (Check only one)	
exeminar? 1 ☐ Yes 25 No	Hospitel: 1 Inpatient 2 ER/Outpatient	3□ DOA Other: 4□ Nursing H	lome 5 Residenca 6 □Other	(Specify)
2 LI ACCIOSITI	igetion	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred	
3 Suicide 6 Could 4 Homicida deteri		fectory, offica	28f. Location (Street end Number City or Town, Stata)	or Rural Route Number,
29e. Certifier 12 Certifyi (Check only 2 Medical	ng Physician: To the best of my knowledge, deeth oc I Examiner: On tha basis of examination and/or invast end manner steted.	curred at the time, date end plece igation, in my opinion, deeth occu	I s, end due to the cause(s) and mann arred et tha time, data and place, an	ner as stated. d due to tha cause(s)

29b. Signature and title of certifier

16

121463

29d. Date signed (Month, Dey, Year) 5-15-2000

30. Name and eddress of person who completed causa of death (Item 23a) (Type, Print)

BRUCE A. SILVER, N'D 110 HOSPITAL RD, PRINCE FREDERICK, MYD 66(78)

32. Registrar's Signeture

State Registrar

filled in by 24 hours e Funeral [Hospital

Medical

within 2. To the F \$

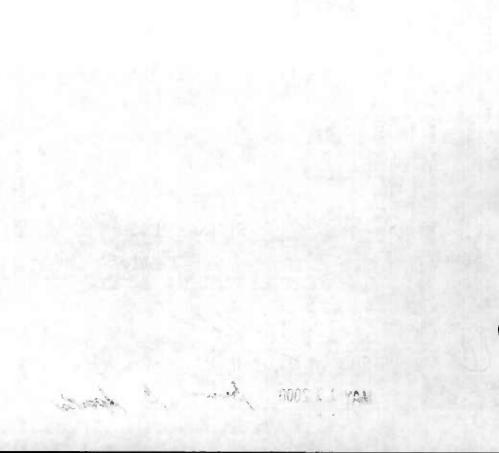
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	Decedent's Neme (First, Middle, L	net)	Cei	rtificate of	Death	2. Dete of De	Reg. No.		3. Tima of Death
nysician	MARIO ANTHONY E					Month	Day	Year	
Medical	4e Facility Neme (If not institution, g				4b. City, Town, or L	May 0		of Death	1055 am
kaminer	Prince George's		enter		Cheverly	7		nce Ge	orges
neral		Sex 7. Age	(In yrs. lest birthdey)	If Under 1 Year	If Under 24 Hrs.			9. Birthple	ce (State or Foreign
ector	218-44-3305	10XXX 2□F 3	Yrs.	Montha Deys	Hours Min.	JUNE	15,1965	PORT	SMOUTH, VA
of all	Usual Rasidence of Decedant 10a. Stete 10b. County		10c. City, Town or Lo	cation				100	d. Inside City Limits
rector								100	N☐ Yas 2☐ No
ect	10e. Street and Number	GEORGES	CAPITOL	10f. Zip Coda			10g. Citizen of V	Mhat Countr	••
Funeral Director	6814 CENTRAL AVE	#402		20743					
era	11. Marital Stetus	12. Was Decedent E	ver in U.S. 13.		Hispenic Origin? (Si	pecify Yes or No	UNITED	SIAIL e - American	
by Fun	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 Xe If Yes, Give Year or Detes:)	If Yes, specify Cub 1 ☐ Yes 2000No	Hispenic Origin? (Spen, Mexicen, Puerto Specify:	o Ricen, etc.)		ck, White, etc y:BLACK	
ted	15. Decedent's I	Education	16a. Dece	dent's Usuel Occup	petion	tina	16b. Kind of Bu	usiness/Indu	stry
Completed	(Specify only highest g	College (1-4or 5+	life.	DO NOT use retire	during most of world)	KIIIY			
Con	Elementery/Secondary (0-12)			DETAILE			PRIVAT		
Be	17. Fether's Neme (First, Middle, Las	()			18. Mother's Nan			ne)	
2	ROBERT ANDREWS					ARA BARI			
	19a. Informant's Name/Ralationship				t end Number or Ru				
	VEDTRA T. GOLDEN 20a. Method of Disposition	-ELLIOTT/ W	IFE 6814		AVE # 40	3 CAPITO	OL HEIGH 20c. Location -		
once.	1 M Buriel 2 □ Cremetion 3		cemetery, crei	metory or other pla					11, 31616
	4 Donetion 5 Othar (Spec		RESURREC			5-11-0		CON, MD	
	21. Signatura di Funeral Service Ido		2	ALE	XANDER S.	POPE F	UNERAL F	HOME	
	23a. Part1. Enter the disease, or of	RAY	the same of the sa		BORO PIKE				7 Approximate
Alcai Examiner	Sequentielly list conditions, if any, leeding to immediate ceuse. Entar Underlying Cause (Disease or injury that initieted events	b	Due to (or as a consecutation of the consecutation					 	
n/Medical	that inflated events reaulting in deeth) Lest	C	ue to (or es e consac	uence of):				1	
icia	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause of	ven in Part i	23h Did	tobacco usa co	entributa to t	the cause of death
by Physician/M		contributing to doubt but	Hot resulting in the u	riderying occase gr	von in raici.		Yes 2 No	3 Probe	
Completed b	STATE OF STATE						an autopsy ormed?	com	e eutopay findings leble prior to pletion of cause seth?
E						128	Yes 2 No	134	Yes 2□ No
Be	25. Wes cese referred to medical axaminer?				26. Placa of Das	ath (Check only	ona)		
0	XXVes 2□ No	Hospitel: 1 Inpatien	t 2X ER/Outpatie	II JU DOA		lome 5 ☐ Resi	idence 6 Oth	ner (Specify)	
Certification:	27. Mannar of Death 1 Deturel 5 Pending investigeti	3 3 100	Year) Injury	Cland) Ma	ry at ork?] Yes 2 No	DRIVER :	how injury occur STLUCK WHILL EXITING VE	HICLE	
	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicida datamine	28e. Plece of Injur building, etc.	y - At home, ferm, str (Specify) STREE		W. D	City or To	Street and Number, State) WES	D HURAL	Houte Number, 214
Aedical	(Check only 2 Medical Exp	hyeician: To the best of miner: On the basis of and menner stet	examinetion and/or in	vestigation, in my	opinion, death occu	, and due to tha irred et tha time,	data end place,	end due to t	the cause(a)
2	29b. Signature end titla of certifier	M. CH			se number		May 06,		ey, Year)
completely filled in Medical Cert	30. Neme and eddress of person who	complated ceusa of decingly, M.D.	111 Pe	O.(ore, Ma	May 06,	2000	oy, real

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedeni's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY WILLIAM BURNETTE EDWARDS, JR. 2000 12:38 AM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth THE JOSEPH RICHEY HOSPICE INC. **BALTIMORE** BALTIMORE 6. Sex 1 M 2 □ F ff Under 1 Yeer If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dale of Birth (Month, Day, Year) Months 578-66-9268 1949 February 1 Wash., DC Usual Residence of Decedent 10e. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No D.C. Washington 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 1807 Channing St., N.E. 20018 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedenl Ever in U,S. 14. Race - American Indien, 11. Marilal Status Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Analyst Computer 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Surname) William B. Edwards, St. Delores Mason 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 Dr. Ulysses G. Moye,II / Friend 5243 Kenstan Drive Camp Springs, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Melhod of Disposition 20c. Location - City or Town, State Dete 1 ₺ Buriel 2 □ Cremetion 3 □ Removal from State Glenwood Cemetery 5-8-00 Washington, D.C. 4 ☐ Donelion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensaa 22. Name end Addrass of Facility Capitol Mortuary, Inc. a 1425 Maryland Ave., NE Wash, D.C. 20002 23a. Part1. Enter tha disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haert failure. List only one cause on each line. Approximele Intarvel Between Onset and Death Immediate Causa (Final diseese or condition rasulting in deelh) 64EMRS Dua to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thal initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Tyes 2 No.

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

þ

Completed

Be

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, fro Martical Examiner must be notified at page.

Baltimore, Maryland

Edwards

ran

12388m

á Completed Be 10

25. Was case raferred to medical examiner?

1 Yas 2 No

27. Manner of Dealth 1 D Natural

2 Accident

3 Suicide

29a. Cartifiar

4 Homicide

P.O. Box 68760 Records, Division of Vital After this death. after death Director.

To the Hospital or within 24 hours all To the Funeral Di edical State

Registrar

29b. Signature

and title of certifie Tobar

5 Pending investigation

6 Could not be detarmined

29c. License number Kyss

1)06933

1 Yes 2 No

28c. Injury al Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

26. Placa of Death (Check only one)

Other: 4 Nursing Homa 5 Residence 6 Dother (Specify) HOSPICE

28d. Describe how injury occurred

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Data signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

address of person who completed cause of death (Ilem 23a) (Type, Print)

300 ARMORY PLACE SUITE 39. BALTIMONE MA 21201 JOHN BMACGIBBON

31. Dale filed (Month, Dey, Year)
MAY 1 1 2000 3. Registrar's Signature

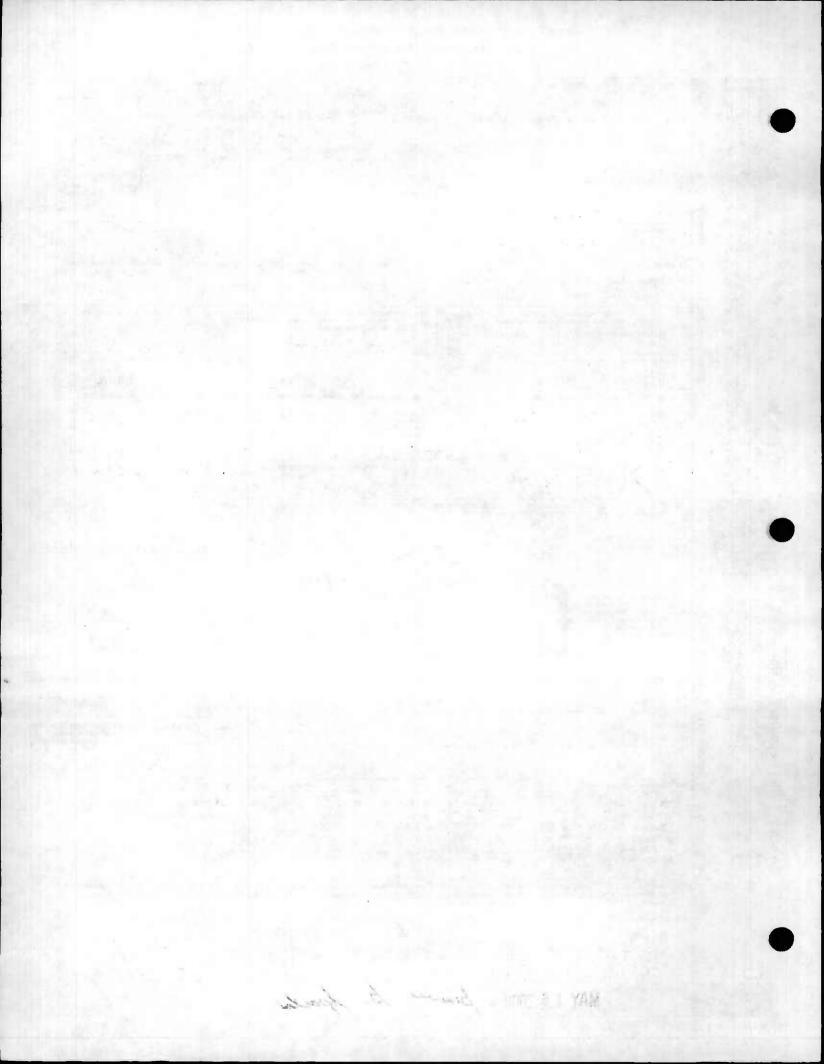
1 ☐ Inpalient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify)

11 2000 Low-

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17049

				Cer	tificate c	of Death	Re	g. No.	
		1. Decedent's Nama (First, Middle, Last	1)				2. Date of Death	1	3. Time of Death
	Physician /Modical	James P	atrick Ferne	n Sr.			Month May	12 200	00 1525
	/Medical Examiner	4a Facility Name (If not institution, give		,		4b. City, Town, or	Location of Death	4c. County of [
		5469 Brooks Wo	ods Road			Lothia	n	Anno A	Arundel
	Funeral	5. Social Security Number 6. Se		last birthday)	If Under 1 Ye	ear If Under 24 Hrs	8. Date of Birth		Birthplace (State or Foreign Country)
	Director	130-26-4061	XM 2□ F 6	5 Yrs.	Months Da	ys Hours Min	Nov 1		New York
	Q .	Usual Residence of Decedent					1107 1	TOOT	TICW TOTA
	bo Mar	10a. State 10b. County	10c. C	ty, Town or Lo	cation				10d. Inside City Limits
:	Ct die	MD Anne Ar	undel	Lothian	1				1 ☐ Yes 2/ No
	vith the Ma or 28a-f a be not the Director	10e. Street and Number			10f. Zip Cod	0	10	g. Citizen of Wha	t Country?
			ds Road		207	11		U.S.A.	
	r from 23 ofper man	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	,S. 13. V	Was Decedent	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
0	P. P. P.		1 Yes 2 No		□ Yes 250			Specify:	
000	iral', o	3 Widowed 4 Divorced	Year or Dates:					Specify.	White
21215-0020	ed within 72 ho ygiene. Ner then "neture ft, tre Medical Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Oc kind of work do	ne during most of wo	rking	6b. Kind of Busin	ass/Industry
2	within 72 ene. than 'nat	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use re	211.			
	Hygie there to Co			Pol	lice Of:				C. Gov't
בו	antial Hygenthal Avant, cavant, Cavant	17. Father's Nama (First, Middle, Last)				18. Mother's Na	ma (First, Middle, M	faiden Surname)	
7 3	Ne de Co					Mae	14 5 3	Jo	nes
-	0	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailin	g Address (Str	eet and Number or R	ural Route Number,	City or Town, Sta	te, Zip Code)
	f Health fram 27 other tr	June E. Fernen		5469	Brooks	s Woods Ro			
=	· - 2 0	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Place of Dispo- cemetery, cren	sition (Name of natory or other	place)	Date 2	20c. Location - City	or Town, State
E .	Pages ment of I ant: If Its ury or o	4 □ Donation 5 □ Other (Specify)		surrect	cion Cer	netery May	17, 2000	Clinto	on, MD
Baitimore,	permit. Pege Department of important: If any injury or page.	21. Signature of Funeral Service Licens	00	22	. Nama and Ad	dress of Facility	ee Funera	1 Home (Calvert, PA
ш	205 2 2	Lange 9	11.	81	L25 Sour	thern Mary			s. MD 20736
		23a Part1. Enter the disease, or composition, or heart failure. List only of	dons that caused the dea			V			Approximate Interval Batween
40	/Medical Examiner	Immediata Cause (Finat disease or condition resulting in death)	Acut.	or es a conseq	gradiumon of):	ac Ar	rhyth	mia	minutes
,00	ing physicien and est the burish-transit. Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	ny			
8	2 5 2	resulting in death) Last	Due to (d	or as a consequ	uence of):				
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0	es trat the death igned by the ette be deteched for by Physicia	Part II. Other significant conditions con	ntributing to death but not re-	sulting in the ur	nderlying cause	given in Part I.			bute to the cause of death?
D . 3	5 60						1 U Y	a 2□ No 3[Probably 4 Unknown
	been s should should						24a. Was ar perform		4b. Wara autopsy findings available prior to completion of cause of death?
	rate hes page 2	0.10.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.					1 ☐ Ya	s 2000	1 ☐ Yes 2 ☐ No
	certificata rector, pag	25. Was case referred to medical				26 Piace of Do	ath (Check only only		10 100 20 110
5		examiner?	lospital: 1 Inpatient 2	ER/Outpatien	1 3 DOA	Other	Home 5 Reside		Speciful.
ō	rithis and district Tr. T.	27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of		njury at Work?	28d. Describe ho	-	эрөспу)
5	to the	1 DNaturat 5 Pending investigation	(Month, Day Year)	Injury		Nork? I∐Yes 2∐No			
= :	rs after death. al Director: After tied in by the funers Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factory, offi	C9	28f. Location (Sti City or Town		or Rural Route Number,
	Funer float float		sician: To the best of my kno ner: On the basis of axamina and manner stated.						
	Within 7	29b. Signature and titla of certifier	an Do.	2241	29c. Lic	ense number	, 25	d. Date signed (N	fonth, Day, Year)
	7 0	11:11. 1	1	7	D	06054	1	5/12	100
		30. Name and address of person who	amplying cause of death (Ne	7 23e) (T	Deine)	. 4		1	Secondle MD
2	15	Milliam D	Toues, w	(Type, I	100	Amora	ica C	+ 101	035
	Charles	31. Date filed (Month, Day, Year)	32. Registrar≱ Sign	ature	193	ITHEY	1-11-	01	
	State Registrar	MAY 1 6	2000 Dene	var	D. 0	portal			



Ammend #17 & #20b Calvert Co. Health Dept. KDS - 05/12/00

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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State of Maryland /	Department o	f Health and I	Mental Hygiene	

- 03/12/00			Certificate of	Death	1	Reg. No.				
	1. Decedent's Name (First, Middle, Last)				2. Dete of Dee Month			3. Time of Deeth		
Physician (Modical	WILLIAM EUGENE	FISH	ER		May	11 Day 20	000° 7	7:30 a.m.		
/Medical Examiner	4a Facility Neme (If not institution, give street and num	ber)	William R. I.	4b. City, Town, or Lo	cation of Deeth	4c. Count	y of Death			
	1662 Paris Oaks Road		Sec. 19 - 12	Owings		Calv	ert			
Funeral	4€ M OF	. Age (In yrs. last birt	Months Dev		8. Dete of Birt (Month, Da)	h y, Year)	9. Birthplee	ce (State or Foreign		
Director	203 20 2400	65	Yrs.		Aug 2,	1934		ylvania		
9 1	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City, Town	or Location				100	f. Inside City Limits		
with the Marylar is or 28a-f show the notified at	Maryland Calvert			vings				1 ☐ Yes 2 📉 No		
or 28s-f	10a. Street and Number		10f. Zip Code			10g. Citizan of	What Country	v?		
William William	1662 Paris Oaks Road			736			USA			
har death w r herra 23s siner must b Funeral I		dent Ever in U,S.	13. Was Decedent of	Hispenic Orlain? (Sp	ecify Yes or No	14. Ra	ce - American	ı Indien,		
har d fiber fun	Armed Ford	ces?	If Yes, specify Cu	Hispenic Origin? (Spoten, Mexican, Puerto	Rican, etc.)	Ble	eck, White, etc	c.		
by F	I HVes Give	as: 1951-71	1□ Yes 2N	o Specify:		Speci	h white	3		
sal is	15. Decedent's Education	169.	Decedent's Usuel Occ	upation			Business/Indu			
Med m	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-	4or 5+)	(Give kind of work don life. DO NOT use reti	e during most or work red)	ing					
ed within 72 ho ygiene. Ar then "netur it, the Medical. Completed	4		gt., U.S.A.	F. small a	arms in	structo	r US	Military		
Be C	17. Fathar's Nema (First, Middla, Last) Willi	am		16. Mother's Nemo			m <i>e)</i>			
Ment Ment Ment Ment Ment Ment Ment Ment	Willai m John Fisher			Mary A	nn Reig	ghard				
2 shot and a shot a sho	19e. Intorment's Neme/Reletionship (Type, Print)		Meiling Address (Stre			er, City or Town	n, State, Zip C	oda)		
and and a 27 wer tr	Marie E. Fisher	S	ame as # 10) above						
自己を	20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from S	20b. Pieca of camater	Disposition (Name of y, crematory or othar p	Metropolit	a Date	20c. Location				
Pag ment ury	4 Donetion 5 Other (Specify)	Metrop	o;itan_Cre	materu 5	¥12-00	Alexar	ndria,	VA		
Depart Depart Iny in	Marie E. Fisher Same as # 10 above									
20128	Willeam Trans	3	Rausch I	Funeral Hor	me, P.A	., Owin	gs, MD	20736		
Physician /Medical Examiner	Immediata Cause (Finel disease or condition resulting in deeth)		Syears							
physician and s the burief transit	Sequentially list conditions,	Due to (or es e o	consequence of):							
certificate be execut ding physician and ise as the buriel-tran VMedical Exam	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury									
licate be physicia s the bur	that initiated events resulting in deeth) Last	Due to (or es e o	consequence of):							
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deeth deeth e atten		14 7								
ires that the deeth of signed by the attended be deteched for und by Physician	Pert II. Other significant conditions contributing to dea	th but not resulting in	the underlying cause	given in Pert I.	\			the cause of death		
± 000	Congestive Hea	rtrail	ine (lor	Pulmonale) *	Yss 2□ No	3 Proba	ibly 4 🗌 Unknov		
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cete ha	Obstructive Sleep M	wea with	hypoven	manow	10	Yas 2 No	10	Yes 2 No		
Physician: The this certificate ral director, page Co	25. Wes case referred to medical examiner? Hospital:	10000	**	26. Plece of Deet						
A sign	1 ☐ Yes 2 ☑ No 1 ☐ In 27. Manner of Death 28a. Dete of	patient 2 ER/Ou	tpatient 3LI DOA	4 Nursing Inc		dence 6 0				
After funer funer	1 Neturel 5 ☐ Pending (Month		Firme of 28c. In No. 1	ork? ☐ Yes 2 ☐ No	26d. Describe	now injury occi	med			
bal or Attending Physician: rs after death. ai Director: After this certific led in by the funeral director, Certification: To Be (2 Accident investigation 3 Suicide 6 Could not be	of Injury - At home to			26f. Location (Street and Nun	ber or Rural	Route Number		
after of All Directiff	determined 266. Pieca C	of Injury - At nome, teg, etc. (Specify)	rm, street, factory, offic	· ·	City or To		or Hurdi			
pital Miled	20a Codifier		double and the district	Aima data :	and due to the			tod		
Hos 24 ho Fun tely i	29a. Certifier (Check only 2 Medical Examiner: On the base	sis of examinetion and								
Mec Mec	2.00	a. Statad.	29c. Lice	nse number		29d. Dete sign	ned (Month, D	ay, Year)		
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert		sis of examinetion and	d/or Investigetion, in m		red et the time,		, and due to t	the ceuse		

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

29d. Dete signed (Month, Day, Year) 2000

James Henderson II 31. Data filed (Month, Day, Year)

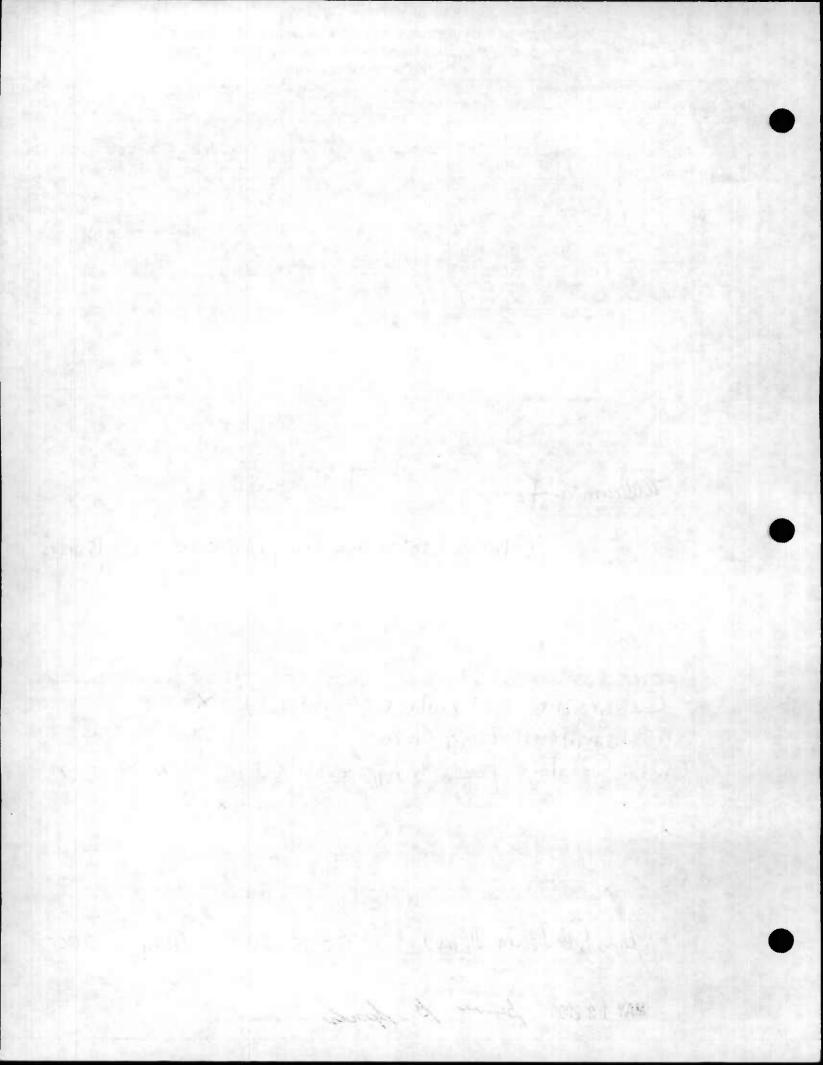
Malcolm Grow Med. Ctr., Andrews AFB, Camp Springs, MD M.D. 32. Registrar's Signatura

MAY 1 2 2000

DHMH 16 Rev 6/95

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State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Dorothy Lee Fields May 7, 2000 6:15AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Care Prince George's Clinton if Under 24 Hrs. If Under 1 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1□M 25 F 89 Yrs. 227-30-0026 Director Jan. 22, 1911 Richmond, VA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Prince George's Clinton 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 9211 STUART LANE 20735 USA "natural", or itsma 23a 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yea, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Mentel Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 BLACK 1 Yes 2 No Specify: If Yes, Give Yeer or Detes: Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Richmond School BD permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 Is marked other any Injury or other traumatic event once. 17 Fether's Neme (First Middle Last) 18 Mother's Name (First Middle Maiden Surname) Be Carrie Furbish Alex Bassfield 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #432 Temple Hills, MD 20748 Doris Beagle / Daughter 3001 Branch Ave. 20b. Plece of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 5-11-00 Quantico National Cem. Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture/of Funerel Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of MD 4308 Suitland Rd. Suitland, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical outmonary Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury P.O. Box 68760, that initiated events resulting in death) Last ancer Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1□Yes 2□No certificate of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: XXNursing Home 5 Plesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Sign of the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Atter Division Attending 5 Pending investigation 1 Natural 1□ Yes 2□No 2 Accident after desti Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely litted is edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and inenner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony Thomas, M.D. 1328 Southern Ave. Wash., DC SUITE 312

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

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Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month **Physician** 5:30AM 8, 2000 Marie May E. Fersinger /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Marlboro Prine bonder 24 Hrs. 8. Dete of Birth Month, Day, Year) Dec. 11,1942 Prince George's

9. Birthplece (State or Foreign 8903 Pensacola Place If Under 1 Year Months Days 7. Age (In yrs. last birthdey) 5. Social Security Number **Funeral** 1 M KRF Washington DC 57 Yrs. Director 577-56-4375 the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. Other than Parturel, or Items 23s or 28s-f show end, the Medical Exeminer must be notified at 1 ☐ Yes 2 TyNo Funeral Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20772 U.S.A. 8903 Pensacola Place permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturer", or items 28 eny hijury or other treumstic event, the Medical Franciscopies. 14. Reca - American Indien, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Merried 1 Yes 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 Navidowed 4 □ Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Precision Hair Design 12th N/AOwner 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Santuccio Santilli Emma Lee Sanford 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 3400 Brookeside Drive Chesapeake Beach MD 20732 Christine E. Dewitt (Daughter) 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 12, 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Dauriel 2 Cremetion 3 Removei from Stete Clinton, Maryland Resurrection Cemeter 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Lee Funeral Home Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 Approximete Intervel Between Onset end Deeth PeN* Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finei disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical Due to (or as e consequenca of): P.O. After this certificate has been signed by the fundaral director, page 2 should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 NO 3 Probably 4 Unknown by Division of Vitai Records. 24b. Were autopsy findings aveilable prior to completion of cause of death? Be Completed 24e. Was en eutopsy performed? 2 N No 1 Yes or Attending Physician: after death. 25. Wes case referred to medical 26. Piace of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatienf Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 Yes 3 DOA 27, Menner of Death 28c, Injury et Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation To the Hospital or Attendir min 24 hours after death. To the Funerel Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Plece of Injury - Af home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29e. Certifie 29d. Deta signed (Month, Day, Year) 29b. Signa 10 of death (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) Registrar's Signeture State MAY 0 9 2000 Registrar

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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle,	Last)		Ceni	ficate of	Death	2. Date of Dea	eg. No.		3. Time of Death	
Physician	Kenneth Frank	lin Foland					Month	Day	Year	10/54 3/	
/Medical Examiner	4a Facility Name (If not institution,		700			4b. City, Town, or L	ocation of Death	07, 2 4c. County	000 of Death	1045A.M.	
LAditimier	MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGE'S									CETE	
Funeral		Sex 7. Age	(In yrs. last bil		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	Year		ace (State or Foreign try)	
Director	Months Days Hours Min.						Jan 29,	Jan 29, 1933 Maryland			
9	Usuel Residence of Decedent		40.07.7								
anyla ahov	10a. State 10b. County		10c. City, Tow Suitl		tion				- 10	0d. Inside City Limits 1 ☐ Yes 2 No	
Peto peto	MD P.G	•	Sulti	anu							
Vith U	10e. Street and Number 6021 Goodfel	low Drive			10f. Zip Code			log. Citizen of			
pearin. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or terms 23s or 28e-f show any injury or other traumatic avant, the Hedical Examinar mant to notified an ancillad and included. To Be Completed by Funeral Director			Treate H.C.	40 144	20746	Name in Origina (Co	anife Van an Na		ed Sta		
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your A	1 ☐ Never Merried 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	MYes 2 N	1972	10	Yes 2 No	Specify:		Specify	v: Wi	nite	
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offie ent,	17. Father's Name (First, Middle, Li	ist)				18. Mother's Nam	e (First, Middle,	Maiden Surnan	ne)		
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shot shot Mand Mand Mand Mand Mand Mand Mand Mand	19a. Informant's Name/Relationshi						Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Co				
alth a 27 is r. tre	Mary Lou Folan	d/ Wife	6021 Goodfellow Drive, Suitland, Mary:					aryla	nd 20746		
the He	20e. Method of Disposition		20b. Place o	of Disposit	ion (Name of tory or other pla	ce)	Date	20c. Location	City or To	wn, State	
permit. Peges 1 and 2 sho Department of Health and Important: If Item 27 is m any injury or other traum pace.	Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Mount	Oliv	et Ceme	tery May	11, 2000	Frede	rick,	Maryland	
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Depa impo any ir	14 9 5	4		Ale	xandria	Ferry Ro	ad, Clir	nton, M	aryla	nd 20735	
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Physician: r this certific and director, TO Be (examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatient	3 DOA ON	her: 4 Nursing H	ome 5 Resid	ence 6 Oth	ner (Specify	v)	
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With to the com	29b. Signature and little of certifier				29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)	
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May 0 2 2000 Comments

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3 Time of Death 2 Date of Death Ellen Griffith **Physician** Dorcas 9, 2000 12:30 P.M May /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Calvert St. Leonard 3820 Williams Wharf Road 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Yrs Oct. 2, 1909 Director 214-05-4042 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits "natural", or Nema 23a or 28a-f show biles! Examiner must be notified at 1 Yes 2 No Director St. Leonard Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3820 Williams Wharf Road 20685 death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married 21215-0020 Specify: White 1 Yes 2 No Specify: p 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) permit. Pages 1 end 2 should be filed within 7. Department of Health end Mental Hygiene. Important: If item 27 is marked other than *na any injury or other treumetic event, the Mexic page. Elementary/Secondery (0-12) College (1-4or 5+) Department Store Purchaser Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Ethe1 Jane Darr P. Copeland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 3820 Williams Wharf Rd. St. Leonard, MD 20685 Celeste Trott/Personal Rep. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removel from State 5/10/00 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Sewell Funeral Home 21 Signature of Funeral Service Licenses 1451 Dares Beach Rd. Prince Frederick, MD 20678 Sewell 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · CONGESTIVE HEART FAILURE DAY Examiner Due to (or as a consequence of): Physician/Medical Examiner ATHEROSCIFACTIC CAPDIOVASCULAR DISERRE YFAR physician end s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of) Box 68760. thet initieted events resulting in death) Lest Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yas 2 No OBSTRUCTIVE PULM SNART DISPAGE Records, 24b. Wera autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: director, 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending ne Hospital or Attendil. In 24 hours after death. The Funeral Director: A pletely filled in by the fu investigetion 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mennar as stated 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certified 30. Name and address of person who completed(cause of death (Item 23a) (Type, Print) FREDERICK, MY- 30678 6 PRINCE WITGEL MO

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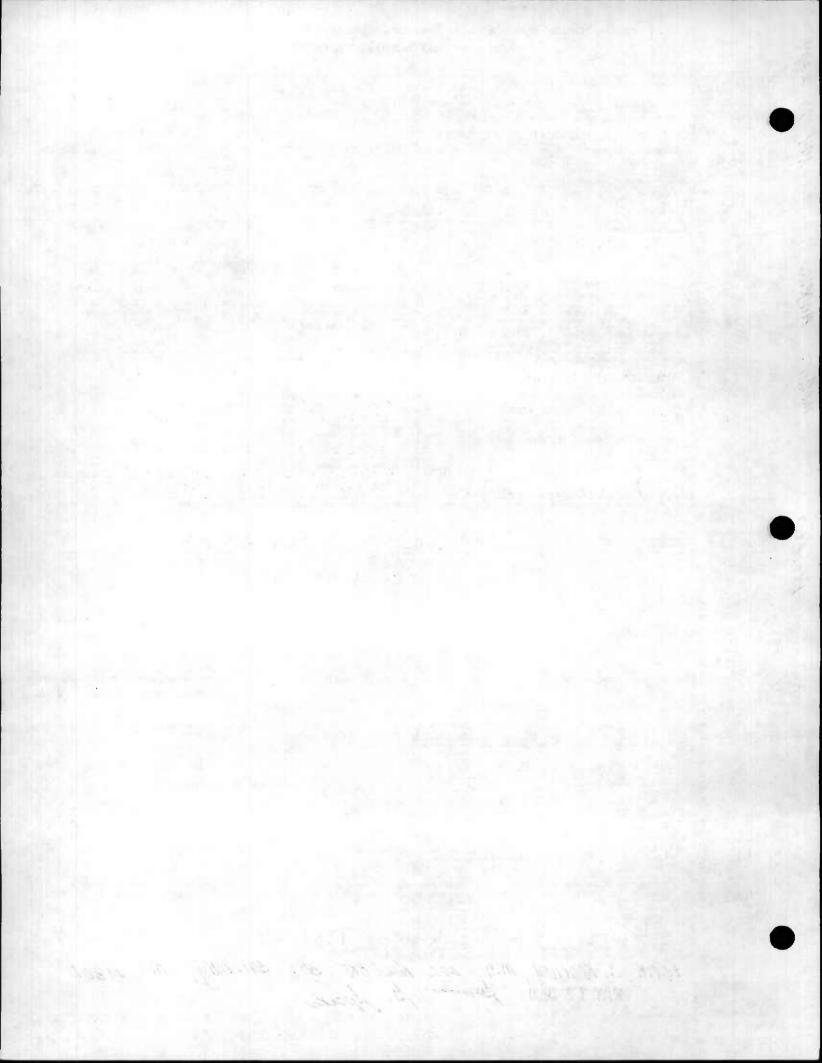
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 400 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Year **Physician** 0.30 ANGEL. DAWN **GORDY** 2000 0 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 10, 2000 Birthplace (State or Foreign Country) **Funeral** 1 M 25 F Months Days Hours Min Maryland Director N/A Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 XYes 2 No Parsonsburg Director Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 7181 Broad St 21849 USA 238 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Raca - American Indian, or items 11 Merital Status Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 ☐ Merried 1 ☐ Yes 2 No White Specify Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a n/a Saitimore, Maryland 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Itam 27 is merked oth Donald Lee Gordy Jr. Angela Bradburn Marie permit. Pages 1 and 2 shoul Department of Health and Me Important: If Itam 27 is meri any injury or other traumeti once. 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela M. Petitto/Mother 7181 Broad St., Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 5/11/00 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature Communication Service Licensee ²² Name end Address of Fecility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 mo1051 CODECUTOR 23a. Part1. Enter the disease, or complications that callsed the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediata Cause (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or s a consequence of for usa as the bunal-trar Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown þ Records, 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 2 1 No 1 Tyes 1 □ Yes 2 □ No certificate of Vital Attending Physician: 25. Wes casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No edical Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Deet! Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division 5 Pending Investigation 1 Natural death. 1 Yes 2 No 2 Accident after death 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 0 Hospital • Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

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State of Maryland / Department of	Health and Mental Hygiene

	Certificat	e of Death		Reg. No.	
	Decedent's Name (First, Middle, Last)		2. Date of Dec	ath	3. Tima of Death
Physician /Medical	LINDA NELLIE GOLDSBOROUGH		Month	4 200	Yaar 00 1429
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or	_	4c. County o	
Zamino	St. Marys Hospital	Leonardto	own	St. Ma	rvs
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under			h	Birthplece (State or Foreign
Director	579-68-5872 1 M 20 F 50 Yrs. Months	Days Hours Min.	February	7, Year) 17,1950	9. Birthplece (State or Foreign Country)) Washington, D
2 .	Usual Residence of Decedent				
the day	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
cto die	Maryland St. Mary's Mechanicsville				1 ☐ Yes 2 ☐ No
or 28s-f	10e. Street and Number 10f. Zig	Code		10g. Citizen of WI	het Country?
after death with the Maryland or Nems 23s or 28s-f show uniner, must be notified at r Funeral Director	P.O. Box #221	20659		U.S.A.	
	11. Maritel Status 12. Was Decedent Ever in U,S. 13. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent Ever in U,S.	dent of Hispanic Origin? (5 cify Cuban, Mexican, Puer	Specify Yes or No	- 14. Race	- American Indien,
F die P	1 Never Married 2 Married 1 Yes 2 No		to riican, etc.)		white white
72 hours after natural, or its dicel Examine eted by Fu	3 ☐ Widowed 4 ☒ Divorced Year or Dates:	ZIZINo Specify:		Specify:	wille
2 ho	15. Decedent's Education 16a. Decedent's Usu	al Occupation		16b. Kind of Bus	siness/Industry
ed within 72 ho ygiene. 4. Iba Medical. Completed	life, DO NOT u	ork done during most of wo se retired)	rking		
twithin the Me	Elementary/Secondary (0-12) College (1-4or 5+) 10 Home maker			Own Hon	ne
ETSE 0	17. Father's Name (First, Middle, Last)		me (First, Middle,	Maiden Sumame)
ked off	Robert E. Leigh	Nellie	Beavers	3	
S = 2 = 1-					Nata Zin Cadal
CV TH. AT ME		s (Street and Number or R ield Lane Ow			stete, ZIP Code)
1 and 2 Health a em 27 is other trau	·				
2222	20a. Method of Disposition XX Burial 2 Cremetion 3 Removatirom State 20b. Place of Disposition (Naticemetery, cremetory of Commetery, cremetory of Commetery, cremetory)	other place)	Dete	20c. Location - C	City or Town, State
Pages hent of int: If Ibs iny or o	4 Donation 5 Other (Specify) Ft. Lincoln Ce	metery May	9, 2000) Brentwo	ood, MD
Department Pag Department Important: I any injury o	21. Signature of Funeral Service Licenses 22. Name an	nd Addrass of Facility T+	Lincol	ln Funera	1 Homo
P P P P P P P P P P P P P P P P P P P	IP ()	F			
100		adensburg Ro			
	23a. Part : Emil the disease, or complications that ceused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.	be or dying, such as cardia	c or respiratory ai	rest,	Approximete Interval Between
Physician					Onset end Death
/Medical	Immediate Cause (Final disease or condition a Probable Myocardial In	farction			
Examiner	resulting in death) Due to (or as a consequence of):				1
<u> </u>	_ Coronary Artery Diseas				t ·
mir mir	0.				1
certificate be associted ading physician and use as the bunal-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury				
buri	Cause (Disease or injury that initiated events				1
ficate be physicia as the bur edical	resulting in death) Last Due to (or as a consequence of):				
E 0 . X	d				
at the death ced by the attendietached for use					
a ed e	Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause given in Pert I.	23b. Dld	tobacco use cont	tribute to the cause of death
es that the de ilgned by the be detached by Physic	Dichotos Mollitus		10	Yes 2 No	3 Probably 4 Unknow
igned be de					
requires that seen signed by hould be delt be dettered by PI			24e. Wes	en eutopsy rmed?	24b. Were eutopsy findings aveileble prior to
_ D = _			pend	medr	completion of cause of deeth?
has b				34	
cate ha			10	Yas 2 No	1 ☐ Yes 2 Å No
Physician: The this certificate ral director, part of To Be Co	25. Was case referred to medical examiner?		eth (Check only o	one)	
2 00	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3			dence 6 Othe	
ding Phy. After thi funeral	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury et Work?	28d. Describe I	how injury occurre	od
	1 Distance 5 Dending (MOIIII, Day Fear) Injury	1 Yes 2 No		-	
atio	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation M		+		or or Rural Route Number,
5955	2 Accident Investigation 3 Suicide 6 Could not be determined to be determined as Place of Injury - At home, larm, street, lector	y, office			
5955	2 Accident investigation M	y, office	28f. Location (: City or To	wn, State)	
5955	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lector building, etc. (Specify)		City or To		ner es steted.
5955	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, larm, street, lector building, etc. (Specify) 29a. Cartifler (Check only 2 Medical Examiner: On the basis of examination and/or investigation	et the time, date end plec	City or To	cause(s) end man	
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he Hospital or Atten in 24 hours after deal he Funeral Director: pletely filled in by the edical Certifica	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, larm, street, lector building, etc. (Specify) 29a. Cartifier (Check only one) 1 Certifying Physician: To the basis of examination and/or investigation and manner stated.	et the time, date end plec	e, end due to the urred et the time,	cause(s) end mar date end piece, a	
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Caca 6	2 Accident 3 Suicide 4 Homicide 29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.	et the time, date end plece, in my opinion, deeth occ.	e, end due to the urred et the time,	cause(s) end mar date end plece, a 29d. Date signed	(Month, Day, Year)
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MAY 1 2 2000 Seemed 2000 1 1 YAK

RAEFORD N. GATLING

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	State of Maryland / Department of Health and Mental Hygiene	7	0	5	8

	1. Decedent's Name (First, M.		Harry C.		tificate of		2. Date of Dea			Tima of Death
an cal	Raeford N.	Gatling					Month MAY	16 20	Year 00	2156
ner	4a Facility Neme (If not institute DOCTORS CC	ntion, give street and n				4b. City, Town, or LANHAM	Location of Death	4c. County PRIN	of Death	ORGES
	5. Social Security Number 574-96-5774	6. Sex 1 XM 2 ☐ F	7. Age (In yrs	i. last birthday) 33 Yrs.	If Under 1 Year Months Days		(Month, Day	Year) 1966		(State or Foreign
	Usual Residence of Decedent 10a. State 10b. Cou		10c. C	ity, Town or Lo	cation		Tray Jo	• 1700]		nside City Limits
To		ce George'			Forestvi	lle				Yes 2□No
ruitei al Directo	10e. Street and Number 2315 Wintergr	een Ave.			10f. Zip Code 2	0747	,	Unite	What Country?	es
complete by the	11. Marital Status 1 Never Merried 2 N 3 Widowed 4 Divon	Armed F Ierried 1 ☐ Yes	2 No		Vas Decedent of Yes, specify Cui ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	ck, White, etc. Black	
	15. Dece (Specify only his Elementary/Secondary (0-1)	dent's Education thest grade completed College	(1-4or 5+)			pation during most of wo ed) Public W		16b. Kind of B	usiness/Industr	
	12th 17. Father's Neme (First, Middo George Jor			D.G. 1	repe. OI	18. Mother's Na	me (First, Middle, ary A. Ga	Maiden Suman		
	19a. Informani's Neme/Relati		. 10.			nt and Number or R				
	Mary Coleman 20a. Method of Disposition	- Mother	20h			green Ave		tville,		0747
	1 Burial 2 Cremetic		Siate		sition (Name of netory or other pla Memoria	1	5/23/200			
	21. Signalure of Funeral Serv		A 7		. Name end Addr		Stewart	Funeral	Home	20019
	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events	a	Due to (or as a conseq		CATION	45901			
	that initieted events resulting in death) Last	d	Due to (or es a consequ	uence of):					
	Part II. Other significant cond	itions contributing to	death but not re	sulting in the un	nderlying cause g	iven in Pert I.	23b. Did to	obacco use co	ntribute to the	cause of death?
							101	'es 2□No	3 Probabl	y 4 Unknown
							24a. Wes a perfor		availat	utopsy findings le prior to ation of cause h?
	25. Was case referred to med			1-65			אסע	es 2□No	1/2XYe	s 2 No
	examiner?	Hospital:	Inpatient 2	ER/Outpatien	3EXDOA O	ther-	eth <i>(Check only o</i> r Home 5 ☐ Resid	100	er (Specify)	
	27. Manner of Death	28a. Dete	of Injury oth, Day Year)	28b. Time of	P 28c. Inje		28d. Describe h			
	2 ☐ Accident inve	estigetion FOUT	ND • 5 - 0 0 se of Injury - At I ding, etc. (Spec	FOUND 9:10 noma, farm, streify) ESIDENC	eel, factory, office]Yes 2][[]No	28f. Location (S City or Tow	n, State) 7		ute Number, OVER PKW
מוכמו		ying Physician: To the	e best of my knobasis of examin	owledge, deeth	occurred et the t		e, end due to the d	ause(s) and me	enner es stated	i.
Med	29b. Signature and title of cert		nner steted.	~ws	29c. Licer O.C.	se number M . E	4	29d. Date signe MAY 1	d (Month, Day .7, 2000	Year)
1	30. Name and address of pers	on who completed cau	se of death (Ite	m 23a) (Type, I	Print)					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** 4:40 AM Evelun 2000 May 05 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's Hospital Cheverly Prince George's | H Under 1 Year | H Under 24 Hrs. 8. Dete of Birth | Months | Deys | Hours | Min. | May 2, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2⊠ F Months 577-36-1581 Yrs. 1927 73 Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle "natural", or items 23s or 28s-f show MD Prince George's Capitol Heights 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6408 Cabin Branch Court 20743 U.S.A. permit. Peges 1 and 2 should be filed within 72 hours effer deeth . Department of Heelith and Mental Hyglene. Important: If item 27 le marked other than 'natural', or itema 23, any injury or other treumatic event, are lettical from man Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3℃Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Treasury Department 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Jordan F. Moore Edith Cosby 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Gardner Jr 6408 Cabin Branch Court Capitol Heights MD 20743 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremetion 3 ☐ Removel from Stete 5-8-00 Beltsville MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Nama and Address of Facility J.B. Jenkins Funeral Home 21. Signeture of Funeral Service Licensee 7474 Landover Rd Landover MD 20785 1 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Obstructive Pulmonam Distare Examiner Due to (or es a consequence of) Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Records, P.O. Box 68760, ettending physicien for use es the burie Due to (or as a consequence of): signed by the et d be deteched fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of ceuse of death? pege 2 should 24a. Was an autopsy performed? 2 1 No 1 Yas 2 No certificate 1 ☐ Yes Division of Vital director, 25. Wes case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 20 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Dete of tnjury (Month, Day Year) funerei 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Neturat a Funeral Director: Aftivities of Funeral Director: Aftivities of Funeral Directors of Fulled in by the fur 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifie completely

State Registrar

To the Vithin 2

(Check only

29b. Signature and title of certified

oun

Hospital 31. Date filed (Month, Day, Year)

MAY 0 8 2000

1 Brown,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Center

MA

Unive

32. Registrar's Signeture

DHMH 16 Rev 6/95

Cheverly

29c. License number

Maryland 20785

29d. Dete signed (Month, Day, Year)

05,

2000

May

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. 7 0 6 0 State of Maryland / Department of Health and Mental Hygiene

hysician					00	, modec	UI L	Death			Reg. No.			
	1. Decede	ent's Neme (First, Midd	lle, Last)					1.5		2. Date of De	ath		Vac-	3. Time of Death
THE PERSON NAMED IN		Earle C.	Gartrel1							Month April 3	0, 20	000	Year	8:09 A.M
/Medical xaminer		y Neme (If not institution		nber)		-	4	b. City, To		cation of Deat		County of	f Death	0.00
	Ch	erry Hill N	Nursing Cer	nter			I	aure	1		Pr	ince	Geo	rges
neral		Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1	rear	If Under	24 Hrs.	8. Date of Bir	th			lace (State or Foreign
ector	220	-05-3045	10 M 20 F		77 Yrs.	Months E	ays	Hours	Min.	May 6,			Mary	
		sidenca of Decedent								7 - 7				
3	10a. Stete			-	, Town or L	ocation							10	Dd. Inside City Limits
miner man be nouned at	Mary.	land Princ	ce Georges	Lai	urel									1 ☐ Yes XIX No
Director	10e. Stree	et and Number				10f. Zip Co	ode				10g. Citiz	zen of Wh	hat Coun	try?
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Funeral	11. Marita	Il Stetus	12. Wes Dece	dent Ever in U.	S. 13.	Wes Deceden	t of Hi	spanic Or	igin? (Sp	ecify Yes or No	- 1			an Indian,
3	1 N	ever Merried ACXMer	Armed For	2 No	-	If Yes, specify				rucart, etc.)			White,	
6		vidowed 4 ☐ Divorced	If Yes, Give			1□ Yes ZX	INO	Specify:				Specify:	whi	te
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ToB	C1.	audius Rola	and Gartre	11				Mary	Vir	ginia G	oss			
j-		ment's Neme/Reletion:	ship (Type, Print)		19b. Meili	ing Address (S						r Town, S	State, Zip	Code)
	Gr	ace E. Gart	trell/Wife			Larch						0708		
once.	20a. Meth	nod of Disposition	100000	20b. PI	ece of Dispo	osition (Name	of		T	Date	20c. Loc	cation - C	City or To	wn, Stete
		Buriel 2 Cremetion		Stete		matory or othe			V	2000	D		_ 1 _ 1	MD.
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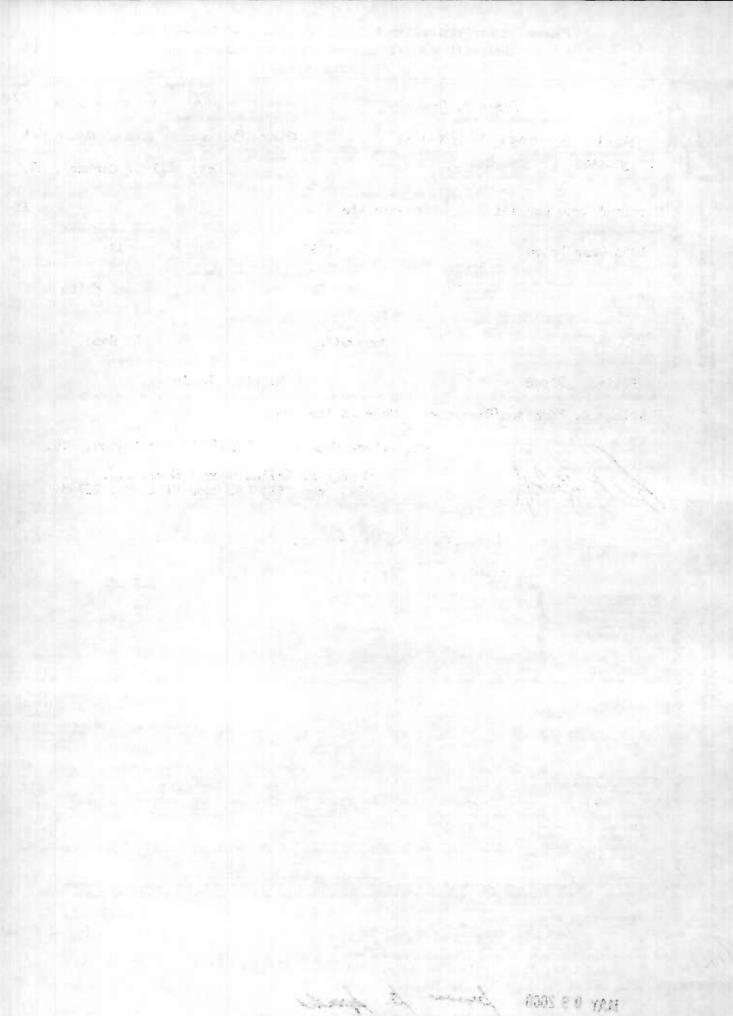
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month MAY Yeer **Physician** 4-15 PM 06 2000 Irene R. Gress /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number, 4c. County of Deeth **Examiner** Burnie Anne Arundel Glen North Arundel Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** Deys Hours 1□ M 2X F Months 577-20-5699 Yrs. Oct. 20,1921 Marbury, MD. Director Usuel Residence of Decedent death with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23s or 26s-1 show other traumatic event, the Medical Examinal must be notified at 1 Yes XX No Crownsville Maryland Anne Arundel Directo 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 1063 Omar Drive 21036 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) At Home Housewife 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Mattie 2 William Rison Bowie 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Itam 27 is any injury or other tra poce. Charlene A. Thompson/Daughter Same as item 10 20e Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Locetion - City or Town, Stete XXBuriel 2 Cremetion 3 Removel from State 5/10/2000 Washington, D.C. Mt. Olivet Cemetery 4 Donetien 5 ☐ Other (Specify) 22. Neme end Address of Facility George P. Kalas Funeral Home, P.A. 21. Signata 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 of plactions that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** KESPIRATORY FAILURE /Medical Immediete Ceuse (Finel HOUTE disease or condition resulting in deeth) Examiner OBSTRUCTIVE LING DISEASE Examiner physician and s the burial-fransit the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting In deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): for use es signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 1 Onknown þ 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: funeral director, 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this 28e. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident ofter deatl 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier 46962 MAY 06, 2000 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) EL HOSPITAL. MD 21061. M.SHIRA 21, M.D. NORTH ARUNDEL HOSPITAL. MD

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gress, Irene

31. Dete filed (Month, Dey, Year) MAY 0 9 2000 37. Registrer's Signeture

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3 Time of Death Day **Physician** Hilda Virginia Hamblen 4b. City, Town, or Location of Death 14 2000 6:10 PM /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 505 Wards Road Dowell Calvert If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthpiaca (Stete or Foreign Country) 6 Say 7. Age (In yrs. last birthday) **Funeral** 1□M 2√F Months Days Hours Yrs. 78 Director 579 18 8306 Usual Residence of Decedent Oct 8 1921 Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itema 23a or 28a-f shov rdical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Calvert Dowell 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Wards Road 20629 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Biack, White, etc. 11. Mentel Status pemit. Pages 1 end 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: if item 27 le marked other than "natural", or item any injury or other treumatic event, the Medical Exercised 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) own home 12 homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Agnes Allen Elmer L. Ward Sr. 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James B. Hamblen-husband 505 Wards Rd. Dowell MD 20629 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donetion 5 ☐ Other (Specify) Paul Cemetery May 17 2000Lusby Maryland 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Furnish Service Licansee 4405 Broomes Is. Rd. Port Republic MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. 206 To Goximate Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) & Maith /Medical Examiner Due to (or as e consequence of) Examiner certificate be executed physicien and s the burial-trens Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): Box 68760. Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of): P.O. I 23b. Did tobacco use contributs to the causs of death? Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy page 2 1 ☐ Yes 2 KNo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical B 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5 AResidenca 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturel 2 Accident 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No after deet Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 2 4 Homicide • Funerel C 16 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the ceuse(s) and manner stated. 29c. License number 3 2 / 46 3 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Prince Fredrick up 20678 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State

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Registrar

MAY 1 6 2000

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2000 May 7PM MARGARET CATHELL HOWARD /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Salisbury Center; Genesis Eldercare Wicomico Salisbury, Md. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 20 F 214-10-8471 85 Director August 4,1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits TYPES 2 No Salisbury Director Maryland Wicomico flams 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 200 Civic Ave 21804 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: b Maryland 21215-0020 1 Yes 2 No Specify: Specify: à White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be find within 72 h. Department of Health and Mental Hygier important if flem 27 is marked any Injury or other. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 10 Housewife Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) William Cathell Helen Walton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Intormant's Name/Relationship (Type, Print) Kenneth A. Cathell/Brother 7040 S. W. 16th St., Plantation, FL 33317 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cramation 3 ☐ Removal from State 5/11/00 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Funaral Sarvice Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association M01051 501 Snow Hill Rd., Salisbury, MD 21804 bompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Revise Porline The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): the burial-tran Box 68760. Physician/Medical Dire to (or as a conse WITH PREETO DOPPRESSION 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown OSTED Proces CS Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☑ No il or Attending Physician: after death. Director: After this certifice funeral director, Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident the 6 Could not be determined 28t. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) P 4 Homicide filled in To the Hospital of within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signatura end title of Suttlier 29d. Date signed (Month, Day, Year) ste 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) me soles mo

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State Registrar

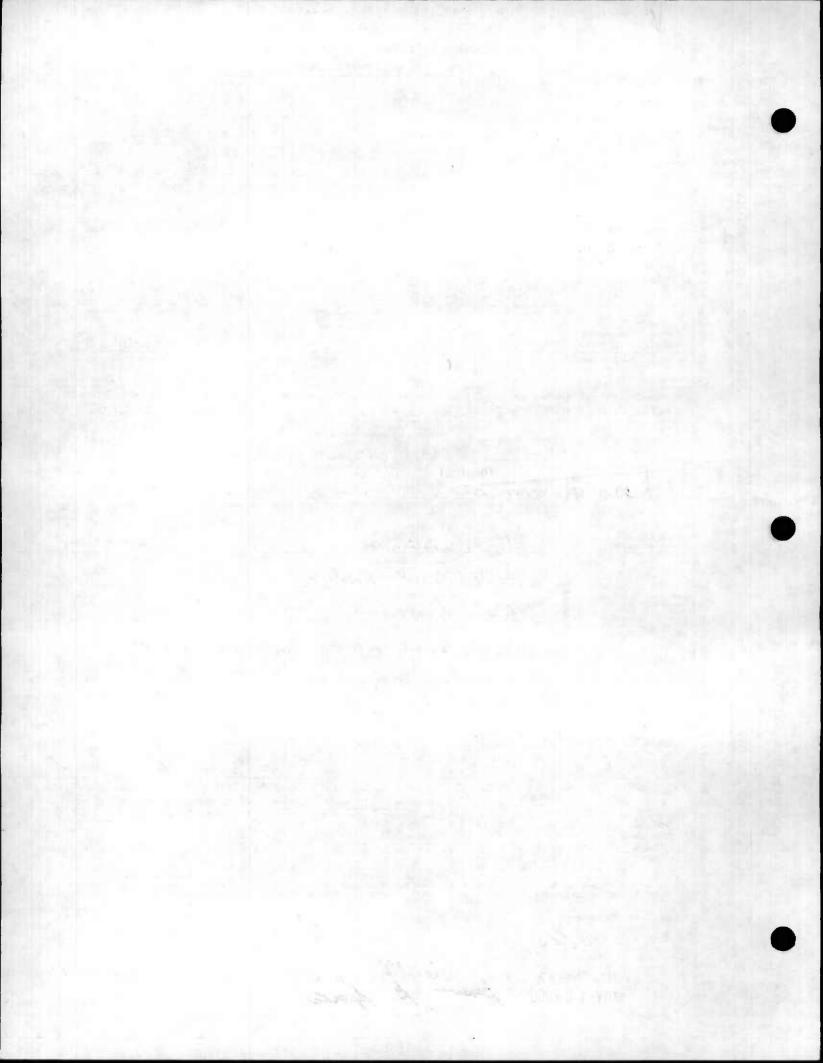
31. Date tiled (Monti

HOWARD

CATHELL

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non 32. Registrar's Signature



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State of Maryland / Department of Health and Mental Hygiene

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ysician	1. Decedent S No	ama (First, Middle,	Last)						2. Date of D Month	eath Da		Year	3. Tima of Death
Medical	MICHA	AEL NOLA	N HILL						May	06		2000	2:40 A.M.
aminer	4a Facility Name	e (If not institution, g	give street end number	er)			4	b. City, Town, or	Location of Dea	th 4c	. County	of Death	
			y and Suit					Suitla		1			rge's
ral tor	5. Social Security 579-96-	-8789	. Sex 7. 1 🛛 M 2 🗆 F	Age (In yrs. 26		If Under Months	1 Year Days	Hours Min		irth 99, Year) 16, 1			place (State or Foreign ngton, D.C.
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by Funeral	1	s arried 2 Married	12. Was Decede Armed Force 1 Yas 2 If Yes, Give Year or Date	s? X No		Was Deced if Yes, spec			Specify Yes or N rto Rican, etc.)	lo-		k, White,	ean Indian, etc. 1 a c k
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ai Examine	Sequentially list if any, leeding to cause. Enter Un Cause (Disease	conditions, immediate inderlying or injury	b		r as a consec		JUL	(6)					
an/Medical Examiner	Sequentially list if any, leeding to cause. Enter Un Cause (Disease that initleted ever resulting in death	HIG	b	Due to (o		quenca of):	Jan	(8)					
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5	resulting in death	h) Last		Due to (or	r as a consec r as a conseq	quenca of): quence of):	ausa giv	an in Part t.			o use cor	ntribute t	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month May 7, **Physician** 4:30PM 2000 John W. Hart /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1122 Valentine Creek Drive Anne Arundel Crownsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 22,1920 Washington, D.C 6. Sax 7. Age (In yrs. last birthday) **Funeral** 17 M 2□ F Months Days Hours Yrs. 579-14-4007 80 Director Usual Residence of Decedent 10a. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Crownsville must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1122 Valentine Creek Drive 21032 12. Was Decedent Ever in U,S.
Armed Forcas?

14. Yes 2 □ No WWII
Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or item any injury or other traumatic event, the London and another than the London and another than London. Black, Whita, etc. 1 Never Married 2 Married 1 Yes 24 No Specify: Specify: White à 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Payroll Supervisor Washington Gas Light Cb. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Hart Edith M. Scala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Randy Hart/Son 2304 Alava Court Waldorf, Md. 20603 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t\OBurial 2 ☐ Cremetion 3 ☐ Removal Irom Stata Maryland Veterans Cem. 5/11/2000 Cheltenham, Md. 4 ☐ Donation S ☐ Other (Specify) 22. Nama and Address of Facility George P. Kalas Funeral Home, P.A. neral Service Licenses alas 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 234. Pan Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical ACUTE MYOCARDIAL INFARCTION Examiner Due to (or as a consequence of): CORONARY ARTERY DISEASE The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760, attending physician for use as the burie Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown CARUTIN ARTERY DISENCE, HYPEKTENSION signed t Records, þ 24b. Were autopsy lindings available prior to Completed 24a. Wes an autopsy performed? PEKIPHEKAL ARTEKIAL DISENSE completion of cause of death? 1 Yes 20 No 1 Yes 2 No cartificate Division of Vitai Attending Physicien: funeral director. 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation Natural ster death.
Director: Att 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or A
 24 hours stier
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 ietely filled in b Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only 29c. License number 29b. Signature and 4 29d. Date signed (Month, Dey, Year) te of certifie am 2000 013072 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gurbux H. Nachnani, M.D. 8926 Woodyard Road #601 Clinton, Maryland 31. Date filed (Month, Day, Year) 3 Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Deet (7) 1. Decedent's Name (First, Middle, Last) Day Year 12-27/14 **Physician** JOHNSON ATWOOD 4-2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Laurel Regional If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Yaar 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Quintry) **Funeral** Months Days Maryland 212-16-7729 83 02-04-17 Director Usual Residence of Decedent with the Marylend 10d, Inside City Limits 10a Stata 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at 1 Yes 2 □ No Brentwood Prince George's Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 20722 3816 37th Place daath Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ★1 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Black, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other treumetic event, the Medical Examin 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: Black à 3℃ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Federal Government Currency Examiner 12th 18. Molher's Name (First, Middle, Meidan Sumema) 17. Falher's Name (First, Middle, Last) 86 Annie F. Johnson Joshua Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 15203 Emory Court Bowie, Md. 20716 Atture Johnson / Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Liberia Church Cemetery 5-13-00 Marion, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensae 22. Nama and Address of Fecility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata tnterval Between Onsat and Deeth **Physician** /Medical Immediala Cause (Final Sepsis 2 Days disease or condition resulting in deeth) **Examiner** Due to (or es a consequence of): Examiner orcinoma rancreas physician and s the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): The law requires that the death certificate be axecu Failure Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) attending ph signed by the a Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy Completed s cartificete hes b 1 Yes 2 No 1 □ Ves 2 □ No Attending Physician: funaral director, 25. Was case refarred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: After 5 Pending s efter de.

N Director: An.

hy the fir 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28a. Placa of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Numbar or Rural Routa Number, City or Town, Stete) 3 Suicida filled in by 4 Homicide 6 • Funeral C Hospital 🕰 Certifying Physicfan: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner es stated. 29e. Certifier Medical plately 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end pleca, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 5/4/2000 29c. License number mod allending 042580 BACUL NO 30. Name and address of person who completed cause of death (Item 23e) (Type, Printy). S. PUJLA MD 5632 ANNAPOLIS Rd 413 BLADENS BURG NO 20710. 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAY 1 1 2000 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month Yeer **Physician** Rudolph Ellsworth Johnson May 6, 2000 1:45 P.M /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL CENTER Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 2 □ F 66 Yrs. Director Nov. 14, 1933 Washington, D.C. 579-42-3602 Usual Residence of Decedent with the Maryland 10a. State Openit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Openment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Medical Examination was be notified at another. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Prince George's Capitol Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 505 Suffolk Avenue, Apt. 416 20743 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Painter Private 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Douglas Lloyd Johnson Etta Catlett 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10624 Joyceton Drive, Upper Marlboro, MD 20 ca of Disposition (Name of Date 20c. Location - City of Town, State Darlene A. Johnson, Daughter 20a. Method of Disposition 1 € Buriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Ft. Lincoln Cemetery 5/13/00 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D.C. 20019 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, chock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) **Examiner** Due to (or es a consequence of): Examiner ai lu re ve The law requires that the death certificate be executed physician end Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Alcoho O. Box 68760 C Physician/Medical Due to (or as a consequence of): ettending for use es Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? the signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, é 24b. Were autopsy findings avelleble prior to should should 24a. Was en eutopsy Completed completion of cause of deeth? s certificate has b 1 ☐ Yes 2 ☐ No 1 Yes 2 LNd Division of Vital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 1 Yes 2 No Certification: To 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Day Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 CMatural 5 Pending To the Hospital or Attendir within 24 hours effer deeth. To the Funeral Director: All completely filled in by the fu deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 (Deartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) end menner es stated. edical 2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner stated. (Chack on) 29c. License number 29d. Date signed (Month, Day, Year) 2000 9 000 54068 30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Prince George

Hospital.

Cheverly- MD

State Registrar sobelle

MAY 0 9 2000

31. Date filed (Month, Day, Year)

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M'9 - Py

32. Registrer's Signature

Decedent's Neme (First, Middle, Las Marie Nellie Joe Facility Nama (If not institution, give Southern Maryland Social Security Number 6. S. 578 03 3153 Isual Residence of Decedent 0a. Stete 10b. County	ones							2. Deta of De	ath		3. Time of Death
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7. Fathar's Name (First, Middle, Last) UNKNOWN							KNOW	a (First, Middle IN	, Maigan Sun	тете)	
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3 ☐ Suicide 6 ☐ Could not be determined	286. Piece of	tnjury - At hom , etc. (Specify)	ne, farm, stre	set, fectory, o	office			28f. Location (City or To	Street end N wn, Stete)	mber or R	lurel Route Number,
9a. Certifier (Check only one) Certifying Physics Certifying Physic		s of examinatio									
9b. Signeture and title of certifier				29c. L	icens	e number			29d. Dete si	gned (Moni	th, Dey, Year)

State Registrar

Physici /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physicián /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be associted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Peter W. Yim,
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wart A. Wild /Brobber inLaw 6722 Berkshire Drive, Temple Hills, MD 20748

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Lee Crematory May 8, 2000

Clinton, Maryland Lee Funeral Home, Inc 6633 Old

Alexandria Ferry Road, Clinton, Maryland 20735

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death MAY 9, **Physician** LAMBERT L. LIND, JR. 2000 9:58 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year)
JULY 18,1918-RHODE ISLAND 7. Aga (In yrs. last birthday) If Undar 1 Yaar **Funeral** Days 039-01-4874 1 M 2 ☐ F Months Hours 81 Director Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinal must be notified at 10d. Inside City Limits Director MD. MONTGOMERY ROCKVILLE 1 Yas 2 No 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 9513- VEIRS DR. 20850 USA Funeral 13. Was Dacedant of Hispanic Origin? (Spacify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian. permit. Pages 1 and 2 should be filed within 72 hours after on Department of Health and Mental Hygiene. Introduce the Table and Mental Hygiene, in them 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Francisco Black, Whita, atc. 1 □ Mas 2 □ No If Yas, Giva Yaar or Datas WW 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Dacadent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) ENGINEER BUSINESS 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be LAMBERT L. LIND MINNIE JOHNSON P 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) PHYLLIS A. LIND- WIFE 9513- VEIRS DR., ROCKVILLE, MD. 20850 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a, Mathod of Disposition 20c. Location - City or Town, Stata Dafa 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) METROPOLITAN CREMATORY-5/16 ALEXANDRIA, VA. of Funeral Servict 22. Name and Address of Facility HYSONG CO., INC. 1300- N ST., NW, WASH., DC at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest in each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) du Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inibated events resulting in death) Last Attending Physician: The law requires that the death certificate be associated P.O. Box 68760, 96 Due to (or as a consequence of): # signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 212 No 3 Probably 4 ☐ Unknown Records, þ Completed 24a. Was an autopsy parformed? 24b. Wara autopsy findings available prior to complation of causa of death? page 2 s 1 🗆 Yas certificate 2 No 1 ☐ Yas 2 ☐ No Division of Vital funeral director, 25. Was casa raferred to medical examinar? Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 UNatural 5 Panding invastigation hours effer death. 1 Yas 2 No 2 Accident 6 ☐ Could not be datarmined 3 Sulcida 28a. Placa of Injury - At homa, farm, straef, factory, offica building, atc. (Spacify) 28f. Location (Straet and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida 6 Hospital 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. Medical 29a. Certifian within 24 hor To the Fune completely fi (Check only \$ 29b. Signatura and titla of certifian 29d. Data signed (Month, Day, Year) 29c. Licansa number 10 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) CHARLES W. KARESH- 9701- VEIRS DR., ROCKVILLE, MD. 31. Data filed (Month, Day, Year, 32 Registrar's Signatura State MAY 1 2 2000 Registra

DHMH 16 Rev 6/95

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Funeral Director	5. Social Security Num 578 18 73	6. 338	Sex X⊋M 2□F	7. Age (In ye	rs. last birthday Yrs.	Months		If Under 2 Hours	4 Hrs. Min.	8. Data of Bi	irth	9. Birthplac	a (Stata or Foreign
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any Injury or other pnce.	20a. Method of Dispos 1 🖾 Burial 2 🗆 0 4 🗆 Donation 5	Cremetion 3 [Place of Disp cematery, cre Gate of					2000	20c. Location		,Stata g Maryla
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Madeline Lyons AMEND ITEMS: #	23 PART I,	State of Maryland A 27 PER MEO G783	Department of Health and Certificate of Death	Mental Hygiene	17073
1. Decedent's	Name (First, Middle, Las	st)		2. Dete of Deeth	3. Time of D

	V. Lyons						Month	Dey	Yeer		
4e Facility Neme //f not institution	Madeline V. Lyons									2101 ~~	
to rasmy trome (it not moments)	4e Facility Neme (If not institution, give street and number)						May 16 ocation of Death		of Death	2101 pm	
				W10-32		Fort Was	shington	Prin			
5. Social Security Number 578-40-4310	Sex 1 M 2 F	7. Age (In yrs. la 69	est birthday) Yrs.			Hours Min.	8. Dete of Birt (Month, Da) 7/22/	h y, Year) 30	9. Birthplace Country) S. Caj	o (State or Foreign	
Usuel Residence of Decedent 10a. Stete 10b. County		10c. City	. Town or Loc	cation					10d.	Inside City Limits	
Md.	P.G.									1∭ Yes 2□No	
10e. Street and Number 322 Gibson Dr		101. Zip Code 2074						-	-	7	
11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Ford 1 Tes :	1 ☐ Yes 2 ☒ No						or No- lc.) 14. Race - American India Black, White, etc. Specify: Black			
15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	ent's Usuel kind of work	Occup	ation during most of work	king	16b. Kind of B	usiness/Indusi	lry	
Elementary/Secondary (0-12)		4or 5+)						D.C. (General Hospita		
17. Father's Neme (First, Middle, La Troy Nelson		18. Mother's Neme (First, Middle, Meiden Surneme) Jennie Mae Lambert									
19e Informent's Neme/Relationship The Ima L. Nelsor	Daughte	r	19b. Mailin 322	Gibs	Street	and Number or Ru	rel Route Number Hill, Md	or, City or Town, 2074!	Stete, Zip Co 5	de)	
	По	000	ace of Dispos metery, crem	sition (Nemo	e of	ce)	Dete	20c. Location -	City or Town,	State	
		lete					/00	Landov	ver, Mo	1.	
21. Signature of Funerel Service Lie	censee \mathcal{U} . (310	22.	Neme end H.S.1 4925	Addre Nash Buri	ss of Fecility nington & coughs Av	Sons Core., N.E.	o.,Inc.	D.C. 20	0019	
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resulting In death) Last	d	d									
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						24a.		an autopsy med?	24b. Were evaila compl of dea	autopsy findings ble prior to letion of cause ath?	
							10	res 2□No		es 2 No	
25. Wes case referred to medicat examiner?	41				1-		th (Check only o	ne)	1		
1 XYes 2 No 27. Manner of Death	1 KJ In			28	c. Injur Wor	y et k?		-			
2 Accident investigat 3 Suicide 6 Could no	lion	M 1 Yes 2 No				28f. Location (S	Street end Numl vn, Stete)	ber or Rural R	oute Number,		
						ne data and ala			nnor os eteta	od.	
		sis of examinati									
					29c. License number		29d. Date signed (M		d Alexander Occ	. Massl	
29b. Signature end title of certifier	1 41			110		M.E.		May 18			
	5. Social Security Number 578-40-4310 Usuel Residence of Decedent 10a. Stete 10b. County Md . 10e. Street and Number 322 Gibson Dr. 11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 17. Father's Neme (First, Middle, La Troy Nelson 19e. Informent's Neme/Reletionship The Ima L Nelson 20a. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specific County New County Nelson 21. Signature of Funerel Service Lie 23a. Pert1. Enter the disease of constitute of the shock, or heart teiture. List or shock, or heart teiture. List or limmediate Cause (Finet disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Wes case referred to medicat examiner? 1 Xives 2 No 27. Manner of Death Xivestigal Suicide 28. Cartifier Pending investigal Suicide 3 Suicide Could no determine 29a. Cartifier Certifying 29a. Cartifier Certifying	Usuel Residence of Decedent 10a. Stete 10b. County P.G. 10e. Street and Number 322 Gibson Dr. 11. Merital Status 12. Wes Decedent 1 Never Merried 2 Merried 3 Midowed 4 Divorced 1 Yes, Giv Year or De 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-17. Father's Neme (First, Middle, Last) Troy Nelson 19e. Informent's Neme/Reletionship (Type, Print) The Ima L. Nelson Daughte: 18 Daughte: 19 Daughte:	S. Social Security Number 578-40-4310 10 M 20 F 69	S. Social Security Number 578 - 40 - 4310 1	S. Social Security Number 10 10 10 10 10 10 10 1	Social Security Number Social Security Num	S. Social Security Number 6 Sex 1 m x 20 F 7. Age (in yx. last birthday) 1 Unider 24 His. 578 - 40 - 4310 10 m x 20 F 7. Age (in yx. last birthday) 10 m x 30 F 10 m x	Social Security Number 6 Sex 7 Age finy st. last brintlesy)	5. Social Security Number 6. Sex 100. Clary North Castler 100. Street and Number 3.22 Gibson Dr. 100. Clary North Hill 100. Clary North Hi	5. Social Sourity Number 5.768 – 4.0 – 4.10 1. M. 2.0F	

State Registrar MAY 1 9 2000

32. Registrar's Signature, Service S. Aparth

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Veer Luvenia Rucker Moore MAY 8 2000 11:30AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Camp Springs Prince Georges Malcolm Grove Hospital If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth
July 13, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 20 F Months Days 414-28-1263 80 Yrs. Georgia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits NYes 2 No Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 U.S.A. 4880 66th Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 t. Maritai Status 1 ☐ Yes ZXXNo If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Telephone Representative 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First, Middle, Meiden Sumeme) Lillie Willis Dave Rucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4880 66th Ave, Hyattsville, Md. 20784 Cassi V. Rucker/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ts Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/13/00 Washington, D.C. Glenwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011 23a. Party inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate interval Between Onset and Death sepsis syndrome Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown mellitus Diabetes 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Alzheimeis Dementia 1 ☐ Yes 212 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2[1] 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Meturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

that the death cartificate be executed P.O. Box 68760. signed by the a Records, cartificata director, this After the

Examiner Physician/Medical by Completed Be edicai Certification: To

Physician

/Medical

Examiner

MD Director

Funeral

Completed

Funeral

Director

e filed within 72 hours after death with the Marylan al Hygiene.
I other than "natural", or itema 23a or 28a-f ahow went, the Medical Exercited at

permit. Pages 1 and 2 should be file Department of Health and Mental Hyy Important: if Hem 27 is marked othe any injury or other traumatic event, pance.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital or Attending Physician: after death. Director: Aft 24 hours a Hospital within 2 To the

Registrar

(Check only one) 29b. Signature and title of certifier C

29c. License number 039550 29d. Date signed (Month, Dey, Year) 5-9-00

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

c. Hajjar, Ji. M.D. George

4850 Forbes Blvd. Lanham, md 20706

31. Date tiled (Month, Dey, Year) MAY 1 2 2000

4 Homicide

29a. Cartifie

Registrer's Signeture

14Y 1 8 2009 See - 1

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death ^{Dey}2000 MAY Month McCAFFREY Physician **EMMA** H. 9, 10:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RIVERDALE PRINCE GEORGES CRESCENT CITIES CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | 9. Birthplece (State or Foreign Months | Days | Hours | Min. | NOVEMBER 27, 1912 | NEW JERSEY 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2\ F 218-66-4758 87 Yrs. Director Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at 1 Yes 200 No MARYLAND PRINCE GEORGES BERWYN HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 늄 20740 UNITED STATES 8505 PAXTON COURT permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a entry fujury or other traumatic event, the Medical Examiner mast energy. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 SUSAN HURLEY JOHN S. HUGG 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 8505 PAXTON COURT, BERWYN HEIGHT MD 20740 19e. Informent's Neme/Relationship (Type, Print) DAVID J. McCAFFREY 20a. Method of Disposition 20b. Plece of Disposition (Name of Date 20c. Location - City or Town, State cemetery, cremetory or other place)
FORT LINCOLN CEMETERY 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 5-12-00 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
FORT LINCOLN FUNERAL HOME INC
3401 BLADENSBURG RD, BRENTWOOD MD 20722 21. Signeture of Funeral Service License une Lans se, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) PNEUMONIA 2 WEEKS Examiner Due to (or es e consequence of) Examiner physician and the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 88 987 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown DEMENTIA CARCINOMA OF THE BREAST WITH BONE should be deta à 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? METASTASIS MALNUTRITION page 2 s hss 2E No 1 Yes 1 ☐ Yes 2 ☐ No cartificate of Vital Attending Physician: funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 28c. Injury el Work? Division 1 DNatural 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: A 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) after A 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier 29d. Dale signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number D25079 MAY 11, 2000 14 -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DON H. YABLONOWITZ MD. 7404 EXECUTIVE PLACE, LANHAM MARYLAND 20706 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State MAY 1 1 2000

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelibie ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month by 6, **Physician** Christine M. McDuffie 2000 7:30 P.M. May /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6000 Longfellow Street Prince Georges Riverdale 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 260-40-0290 1 M 2 TF 69 Georgia Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyderie. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any Injury or other traumatic avant, the Wedgel Examinal must be notified anonce. 28a-f ahow 1 ☐ Yes 2 ☐ No Director Prince Georges Maryland Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6000 Longfellow Street 20737 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laundry worker Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Wilmon A. Woodum Ruby Mae Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5999 Emerson St. #506 Bladensburg, MD 20710 Ruby M. Woodum/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery May 12,2000 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21 Signature of Funeral Service Licenses 3401 Bladensburg Rd. Brentwood, MD 20722 alex 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hearth arise. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or es a consequence of): Box 68760 certificate be Physician/Medical Due to (or as a consequence of): P.O. signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Ves 2□ No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? should b Completed 24a. Was an autopsy page 2 200 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No P this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by 4 ☐ Homicide 29a. Certifier edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn A. Hammett, M.D. 344 University Blvd. # 326 Silver Spring, MD 20901 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State

DHMH 16 Rev 6/95

Registrar

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300 - 200 May 1 1800

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Yeer **Physician** JOHN MILLER DAVID 1855 MAY 2000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Baltimore 5 HOSDIta 7. Age (In yrs. lest birthdey) Johns Hopkins if Under 1 Yeer If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number **Funeral** Days 1□XM 2□ F NEW HAVEN CONN. 047 28 1506 64 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete event, the Medical Examiner must be notified at 1 Yes 2 No CHESTERTOWN Director MD Kent 10f. Zlp Code 10g. Citizen of What Country? 10a Street and Number 221 BIRCH RUN ROAD 21620 U.S.A. Funerai 13. Was Decedent of Hispanic Ortgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married WHITE 1 Yes 2 No Specify Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS EXECUTIVE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) permit. Peges 1 end 2 should be i Department of Heeith and Mental I Important: If item 27 is marked or any Injury or other traumatic eve MARJORIE OLIVE WILLIAMS JOSEPH SEWARD MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FRANCES A. MILLER 221 BIRCH RUN ROAD CHESTERTOWN MD. 21620 20b. Placa of Disposition (Neme of cemetery, cremetory or other ple 20c. Location - City or Town, State 20a. Method of Disposition CHESAPEAKE CREMATORY 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/9/00 BELTSVILLE MD. 21. Signature of Funeral S Que Licepse 22. Name and Address of Facility POPE FUNERAL HOME, 11315 LOCKWOOD DRIVE SILVER SPRING MD. 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate tntervat Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Sepsis Examiner Due to (or as a consequence of): Examiner Aspergillosis Pulmonary Aspe 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Volvulus Cecal week Physician/Medical Due to (or es e consequence of): Part fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Bilateral þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed deer venous thrombosis 1 Yes 2□No 1 Yes 2 No 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Dey Year) 27. Manner of Death 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 TYes 2 □ No 2 Accident

physician end s the burial-transit The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, ous after death.

•ral Director: After this certificate has I filled in by the funeral director, page 2.3 Hospital or Attending Physicien:

within 24 hours a To the Funeral C completely filled

23a or 28a-f show

natural, or items

Hygiene.

la marked other

Peges 1 end 2 should be filed within 72 hours after

Baltlmore, Maryland 21215-0020

edicai To the

State Registrar 29b. Signeture and title of certifit

6 Could not be determined

3 Suicide

29a. Certifier

4 T Homicide

31. Dete filed (Month, Day, Year)

MAY 1 1 2000

29c. License number

Street

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

21287-9166

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

M.D. person who completed cause of death (frem 23a) (Type, Print) 30. Name end a

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6,2000

Baltimore MD

John

North 600

32. Registrar's Signature

Comment of the state of the sta

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MICHAEL W. MOLITOR MAY 4, 2000 6:58 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGES If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 1X M 2□ F Yrs. SEPT. 3,1942 WASHINGTON, DC **Director** 213-407262 Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f ahow must be notified at 1X Yes 2 □ No CHARLES WALDORF Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9 238 4782 BRYANTOWN ROAD 20601 USA Funeral death Harms ; Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Status Black, White, etc. The Medical Examiner filed within 72 hours efter I ☐ Yes 2 No If Yes, Give 1 Never Merried 2 ☐ Married 6 1 ☐ Yes 2 No Specify: SpecifWHTTE. Completed by 3 Widowed 4 Divorced Year or Detes: natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 TILE SETTER CONSTRUCTION permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, page. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be CARL W. MOLITOR HANNAH DORTS M. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TIMOTHY M. MOLITOR/ brother 12609 IVYSTONE LANE, LAUREL, MD. 20708 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition Date 3 □Removal from State HUNTT CREMATORY 1 ☐ Burial 2 ☐ Cremation MAY 6,2000 WALDORF, MD. city) 94 Signeture of Auretal Service Licens 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME INC 16000 ANNAPOLIS ROAD, BOWIE, MD. 20715 23a. Part Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or lear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physicián Immediete Cause (Final diseese or condition resulting In deeth) /Medical RESPIRATORY FAILURE Examiner Due to (or as e consequenca of): Physician/Medical Examiner CANCER OF COLON-METASTATIC The lew requires that the deeth certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury and Due to (or as a consequenca of): physician that initiated events resulting In death) Last Due to (or es e consequence of): Po dateched f 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings evailable prior to completion of cause of death? page 2 should Be Completed 24a. Was an eutopsy performed? certificata has 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury aftar death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident the To the Hospital or Atterwithin 24 hours after dei To the Funeral Director completaly filled in by th 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29a, Certifier Medicai 295. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D23743 MAY 4, 2000 30. Name and address of person who completed cause of Jeath (Item 23a) (Type, Print) MARTIN D. WELTZ, 7525 GREENWAY CENTER DRIVE, GREENBELT, MD. 20720

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Registrar

31. Date filed (Month, Day, Year)

MAY 0 8 2000

21215-0020

Baitimore, Maryland

Box 68760.

P.O. 1

of Vital Records,

Division

22. Registrar's Signeture

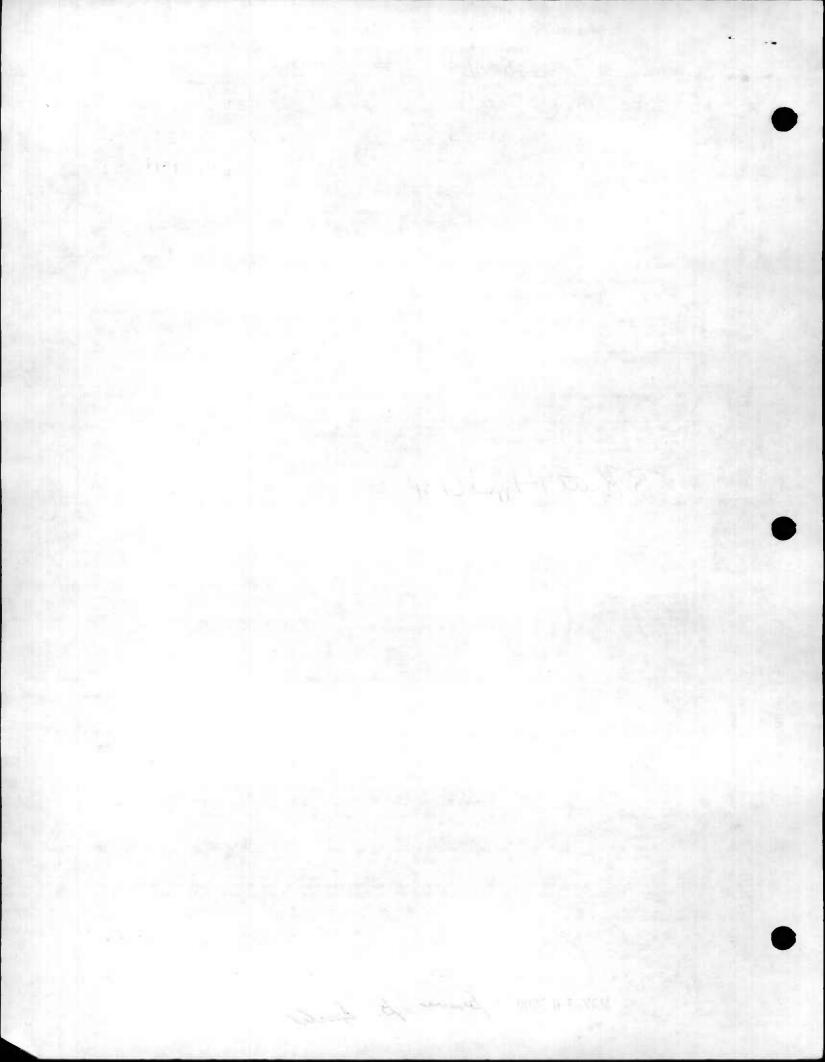
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No.				
Physician /Medical	Decedent's Name (First, Middle, Last) ERROL GOLDSBOROUGH PRITCHETT JR.	2. Dete of Death Month Dey 1 2 20	Yaar 1635			
Examiner	4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Loc Dorchester General Hospital Cambride					
Funeral Director	5. Social Security Number 217–16–9998 6. Sex 127M 2 F 80 Yrs. 6. Sex Months Deys Hours Min.	8. Dete of Birth (Month, Dey, Year) Aug. 28 1919	Birthpleca (Stata or Foreign Country) Maryland			
or the Mayand or the show be notified at	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Dorchester Cambridge		10d. Inside City Limits 1 ☐ Yes 21 No			
th with the Mu 23e or 28e+1s unt be notified ral Director	10e. Street and Number 106 Choptank Terrace 10f. Zip Code 21613					
020 // C uns after dos st', or items Examiner m by Funes	11. Maritel Stetus 11. Maritel Stetus 11. Mes Decedent Ever in U.S. Armed Forcas? 11. Mes Decedent of Hispenic Origin? (Specify Cuban, Mexican, Puarto R II Yes, Specify Cuban, Mexican, Puarto R II Yes, Given 1940-45	lican, etc.) Ble	14. Rece - Amarican Indian, Bleck, White, etc. Specify: white			
I 21215-0020 6 ad within 72 hours after splens. we than "natural", or it it, the Medical Examin Completed by Fu	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	g	construction			
		(First, Middle, Meiden Surner lie Beatrice	me)			
Maryland nd 2 should be fiss sith and Mental Hy 27 is marked other r traumetic event	19e. Informent's Neme/Reletionship (Type, Print) Betty P. Dobson – sister 19b. Meiling Address (Street end Number or Rural 106 Choptank Terrace,					
Baltimore, smill. Pages 1 a uppertment of Hea mportant: if them my injury or othe mos.	20e. Method of Disposition ### Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Pleca of Disposition (Neme of cematery, cremetory or other plece) Dorchester Memorial Park 5		- City or Town, State idge, Maryland			
Balt permit. Departrimports any inja	21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility Tho 700 Locust St. Camb		neral Home PA MD 21613			
68760, tificate be executed Neg physician and as the bunet-transit	Cause (Disease or Injury c.		Interval Between Onset end Death Fhrs No. 1			
SOX in the certification of the second of th	Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco uee co	ontribute to the cause of death?			
ds, P.O. Ruines that the decision of the alid be detached for day Physic		1 □ Yee 2 No	3 Probably 4 Unknown			
		24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of causa of deeth?			
	25. Wes case referred to medical 26 Place of Deeth	1 ☐ Yes 2 No	1□Yes 2 No			
- 2 50	examiner? Hospital: A	(Check only one) ne 5□ Residenca 8 □Ot	her (Specify)			
VISION Of Attending Physic death. ector: After this by the funeral di	1 Netural 5 Pending (Month, Dey Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No	28d. Describe how injury occurred				
Division (tal or Attending P ts after death. al Director: After t led in by the funer Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)				
he Hospi in 24 hou he Funer pletaly fill edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, et al. (Check only one) Medicat Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurre and manner stated.	d et the time, dete end place	, and due to the cause(s)			
To the Within Common	29b. Signeture and title of certifier **Nulliam Pari 29c. License number 043 23 8	29d. Dete sign 5 12	ed (Month, Dey, Year)			
		ambridge	mp 21613			
State Registrar	MAY 15 2000 32. Registrer's Signature &. Sparks					

MAY I 5 2000 from B. front

	Amended #8/05-10- 1. Decedent's Name (First, Middle, La.		ILC Ce	rtificate of	Death	2. Date of D	Reg. No.		3. Tima of Death	
an	Helen May	Purcell				Month	Day	Year		
al	4a Facility Nama (If not institution, giv				4b. City, Town, or	MAY ocation of Dea	9, 200 th 4c. County		10:50PM	
ner			DEDGINE				,			
	SALISBURY CENTER 5. Social Security Number 6. S		n yrs. last birthday)	If Under 1 Yea		URY, MD		MICO	lace (State or Foreign	
			80 Yrs.	Months Days		8. Date of Bi (Month, D	ay, Year)	Count	lace (State or Foreign try)	
	Usual Residence of Decedent					1 11	1 1-411	DEL	LAWARE	
	10a. State 10b. County	10	Dc. City, Town or Lo	ocation				10	Od. Inside City Limits	
ō	MADVIAND COMEDCE	T	DDINCECC	A NINIE					1 ☐ Yes Ž∏ No	
Directo	MARYLAND SOMERSE 10e. Street and Number	1	PRINCESS	10f. Zip Code			10g. Citizen of V	What Count	tn/?	
	P O BOX 436				1853				.,.	
Funeral	11. Marital Status	12. Was Decedent Eve	r in 11 C 12 1			nosifu Voc or N	U.S.A	e - America	an Indian	
	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 █ No	13.	If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	Rican, etc.)	Blac	ck, White,		
	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Yes 2∑ No Specify:			Specify	/: T.TII	TTE	
	15. Decedent's Ed		16e Door	dent's Usual Occ	unation		16b. Kind of B		ITE	
Politica	(Specify only highest gra	ide completed)	(Give	kind of work don	e during most of wor ed)	king	100. Kind of Di	usii 1633/11 10	Justry	
	Elementary/Secondary (0-12)	College (1-4or 5+)			50)		CHIDE	E A CEIO	.n.v	
	8 17. Father's Name (First, Middle, Last)		SEAM	ISTRESS	19 Mothar's Nas	on /Eiret Middle	SHIRT :		KI	
20	JOSEPH O'NEAL				ETHEL	COLLINS		,		
2								0.00		
	19a. Informant's Neme/Relationship (PHILLIP J. PURCEL				et and Number or Ru				Code)	
				30X 436	PRINCI	27.0783	E, MD 21			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			matory or other pi		Date	20c. Location -			
	4 Donation 5 Other (Specific		SPRINGHI	LL MEMOR	Y GARDEN\$	5/12/0	O HEBRO	N, MA	ARYLAND	
	21. Signature of Funeral Service Licen	isee))	22	2. Nama and Add	ress of Facility		705 E. 1	MAIN	ST.	
	5. Keit	1 tream	EXOBO	DUNDS FUI	NERAL HOMI	E. TNC.	SALTSBI	IRY.	MD 21804	
	23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications the caused the						,	Approximate	
	shock, or heart failure. List only	one cause on each line.			Interval Between Onset and Death					
	Immediate Cause (Final								3 1000	
	disease or condition resulting in death)	8.	preum	enla				i	s days	
ь		Dú	e to (or as a conse	quence of):				1		
		b								
E-Aariiii o	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
	Cause (Disease or injury	C. Dark (see a see a								
1000	that initiated events resulting in death) Last	Due	to (or as a consec	uence of):				- 1		
5!		d						1		
ĕ								- !		
Physician/	Part If. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of			
	anemia						1 ☐ Yes 2 ☐ No 3 ☐ Prot			
6	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1									
	caronary art	tery disease cardiomy opathy					s an autopsy formed?	ava	ere autopsy findings allable prior to	
Completed		- 1	1.4						mpletion of cause death?	
E	congestive	Cardiony	pathy			10	Yes 22No	10	Yes 2□ No	
80	25. Was case referred to medical	,	1		26. Place of Dea	th (Check only	one)			
0	axaminer?	Hospital:	2 ER/Outpatier	nt 3 DOA	Whor		sidenca 6 Oth	er (Specifi	v)	
	27. Manner of Death	28a. Dete of Injury (Month, Day Yo		1			how injury occur		//	
Certification:	Natural 5 Pending investigation		sar) Injury		ork? □Yes 2□No					
	3 ☐ Suicide 6 ☐ Could not be	9	- At home form et			28f. Location	(Street and Numb	oer or Rura	I Route Number	
	4 Homicide determined						own, State)			
!	29a, Certifier 3P Certifying Ph	unicione To the house of	us lamanada da esta de esta		sione determine	and due to			and a	
agica:		ysician: To the best of miner: On the basis of ex	amination and/or in							
E		and manner stated		20e Lieu	nse number		20d Date sign	d (Marth	Day Vaer	
~	29b. Signature and title of confifier	//					29d. Date signe	INONIN, I	Day, Todir)	
	- bal se	ul	Divid.		E180E(JUE	7/	0/0	U	
	30. Name and address of person who	completed cause of deat	n (Item 23a) (Type,	Print)	4 1	-				
	Charles B. S.	Ivia Jr	MD	Salis	my Cente	r Genz	eris Elder	-Gore		
e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		my Cente					
r	MAY 10	2000 \$ 50	neva	6 1	_					
				100	och					
5										

DHMH 16 Rev 6/95



_						Cei	rtificate	e of	Death		leg. No.			
Physicia		ian	Decedent's Nama (First, Middle, Last) Bille George P.					1		2. Data of Dea Month	Day	Yaar	3. Tima of Death	
Ġ,	/Medi			Geor	ge		Pic	ker		May	01 20		12:30 P.M	
6	Exami	ner	4a. Facility Nama (If not Institution, MALCOLM GROW ME		R				4b. City, Town, or L CAMP SPRI				EORGE'S	
	Funeral Director		225-52-7613		a (In yrs. las 59	t birthday) Yrs.	If Undar Months		If Under 24 Hrs.	8. Data of Birtl (Month, Day Nov 12			lace (State or Foreign stry) SSISSIPPI	
	pur *		Usual Rasidance of Decedant 10a. Stata 10b. County		10c City 7	Town or Lo	cation					1	0d. Inside City Limits	
	Menyl	tor										1 ☐ Yes 2 ☐ No		
	s with the	il Director	10e. Street and Number 8111 Wellington	Rd.			10f. Zip		308		10g. Citizen of	What Coun		
and 21215-0020 be filed within 72 hours efter deeth with the Menyland tiel Hyglene. d other than "natural", or items 23a or 28s-1 show event, the Medical Examinat mail be incitified at	by Funeral	11. Meritel Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forcas?	Wes Decedant Evar in U,S. Armed Forcas? 1 □ Yas 2 □ No If Yas, Giva ^ 1[8. Was Decedent of Hispanic Origin? (Specify It Yas, specify Cuban, Maxican, Puarto Rica		pecify Yes or No- Rican, atc.)		ce - Americ ck, Whita,	merican Indian,			
Ç O	72 ho	eted	15. Decedent's (Specify only highest	Education orada complated)	1	6a. Deced	dant's Usual	l Occu	pation during most of work	rina	16b. Kind of B	usiness/inc	tustry	
121	vithin han	Be Completed	Elamentary/Secondary (0-12)	Coilega (1-4or 5	+)	16a. Decedant's Usual Occupation (Giva kind of work dona during most of wo life. DO NOT usa retired) Plumber		ed)		Tan	- 1 # E			
9	e filed v al Hygie other t	3	12 17. Father's Nama (First, Middle, L	1		LT	ullber		18. Mothar's Nam	a /First Middle		a1 #5		
2	2 2 2 5	To Be	Charles Pickeri							vellyn V		ila)		
	es 1 and 2 should be f of Health and Mentel I I item 27 is marked of f other traumatic eve		19a. Informent's Name/Rajationshi Janice Pickerin	p (Type, Print) g/Wife	rpe, Print) Wife		19b. Mailing Addrass (Street and Number or Ru 8111 Wellington R		Rural Routa Number, City or Town, Stata Rd. Alex. VA 2230					
gaitimore,	permit. Peges 1 a Department of He- Important: If Item any Injury or othe		20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 4 □ Donation 5 □ Othar (Spe	B □Removal trom Stata	cem	20b. Place of Disposition (Name of cematary, cramatory or other place) Mt Comfort Cemetery 5				Dete 20c. Location - City or Town, Steta 5/4/2000 Alexandria, VA				
<u>=</u>	partm porter yorter		21. Signature of Funeral Service C					-	ess of Facility					
מ	Depar Impo		1 2 1/2	1	MUII	41		Eve	rly-Wheat	-				
			23a. Part1. Enter the disease, or a shock, or haar tailura. List o	tetions thet caused	the daeth.	Do not ant	ar the mode	of dy	ing, such as cerdiac	Braddock or respiretory en	CRd.A.	lex.	Approximete	
ŊÌ	Physician			Outside On Each Int									Intarval Batween Onset and Death	
	/Medical Examiner		Immediate Causa (Final disaase or condition rasulting in daath)	MYO	CARDIA	AL IN	FARCT	ION				į	30 MINUTES	
		e.	tasuming in daam)		Dua to (or as a consequence of): AORTIC DISSECTION									
	d d ansit	Examiner		b								i		
68/60,	icate be executed physician and s the buriel-transit		Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated evants causting death) Lest Due to (or es e consequanca of):											
2X 68/	0.0	//Medical	rasulting in death) Last	d	Due to (or es	e conseq	uanca of):							
00	death e etter ed for u	iciai	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did								Ild tobacco use contribute to the cause of death?			
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Š,	requires thet been signed b hould be dete	by								ANSAN AN		T =		
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Ž Ž	sician: The law sertificate hes b director, page 2 s	Completed								1 D Y	as 20 No		dáath?]Yas 2□No	
	an: T	8	25. Was casa ratarred to medical						26. Plece of Daet			') Tas 2 10	
>	2 0 0	To B	axaminar? 1 ☐ Yas 2 No	Hospital:	nt 2XER	/Outpatien	t 3 DO	A Oti	han			er (Specify	()	
	the fact		27. Menner of Death Natural 5 Panding 2 Accidant	28a. Date of Injur (Month, Dey	Year) 28	b. Tima of Injury	M 28		Injury at Work? Yas 2 No					
	al or Attending F s efter death. Il Director: After I od in by the funen	Certification:	3 Suicide 4 Homicida 6 Could not be datermined 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rura City or Town, Steta)								per or Rura	Route Number,		
	To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifiar (Check only one) 2 Medical Ex	Physician: To the bast of aminer: On the basis of and manner stal	axeminetion	dge, deeth and/or inv	occurred a	t tha ti	ma, data and pleca, opinion, daath occur	and dua to the cred at the time, c	ause(s) and malete and plece,	annar as st and dua to	ated. the ceuse(s)	
	To th To th comp	Me	29b. Signature and title of certifier	7~1/	1		29c.	Lican	sa number	2	9d. Data signe	d (Month, I	Day, Year)	
	0		Mary	J. Ske	4			C	1 0004095		MAY 10	2000		
	(10)	100	30. Nama and addrass of person w	no complated causa of de	eath (item 23	Be) (Type,	Print) {	89 1	MDG/1050					
			MARY F HART,	MAJ USAF , 1					NDREWS AL				762-6600	
	Sta Registr		31. Deta tiled (Month, Dey, Year) MAY 1 1 200	33. Registra	r s Signetura	4.	Loon	1	,					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth ^{Dey} 2000 **Physician** MINNIE Μ. **PARKS** 06, MAŸ 11:45 PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** THE CASEY HOUSE ROCKVILLE MONTGOMERY COUNTY 5. Sociel Security Number 579-56-3465 7. Age (In yrs. last birthday) 58 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth DEC. 05, 1941 6. Sex 9. Birthplece (State or Foreign **Funeral** 1 M 2 XX Months Deys Hours Director Usual Residence of Decedent 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MARYLAND PRINCE GEORGES UPPER MARLBORO XX Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 10011 NEW ORCHARD DRIVE 23a 20774 UNITED STATES Funeral or items 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: AFRO-AMERICAN by "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) REHABILITATION/MEDICAL College (1-4or 5+) OCCUPATIONAL THERAPIST 12TH permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If New 27 is marked oth any Injury or other traumatic event once. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Be WILLIAM RUCKER JESSIE CABELL SMITH 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) CUMBERLAND PARKS/son 8715 BASKERVILLE PL., UPPER MARLBORO, MD vertention 3 | Function | Service | 20b. Plece of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 oremetion 3 Removel from State 4 Donation 5 other (Specify) LINCOLN MEMORIAL CEMETERY 05-12-2000 SUITLAND, MARYLAND 22. Name and Address of Facility DUDLEY FUNERAL HOME EDWARD M. DUDLEY 20712 MT. RAINIER, MD 3200 RHODE ISLAND AVE., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician METASTATIC COLON CARCINOMA Immediate Cause (Final disease or condition resulting in death) 1 YEAR /Medical Examiner Due to (or as a consequence of): Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-tra Box 68760. 8 certificate 4 Due to (or as a consequence of): 950 ğ P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2KNo 3 Probably 4 Unknown Records. þ 3 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? certificate has page 2 2 1 Yes XX No 1 ☐ Yes 2 ☐ No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 XX other (Specify HOSPICE Certification: To 1 Yes KN No to 4 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attor Division Attending XX Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 T Spicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number. City or Town, State) 3 4 Homicide 6 To the Hospital within 24 hours of To the Funeral completely tilled Hospital XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signat and title of partition 29c. License number 29d. Date signed (Month, Day, Year) D37620 MAY 07, 2000 30: Name ion who completed cause of death (Item 238) (Type, Pfint) MARK GODEC, M.D. 6001 MUNCASTER MILL ROAD, ROCKVILLE, MARYLAND 31. Date filed (Month, Day, Year) MAY 1 0 2000 32. Registrer's Signeture State

B. Sports

DHMH 16 Rev 6/95

Registrar

HAY D. I. YAM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death Day **Physician** Edith Violet Pumphrey 4, May 2000 6:32 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Magnolia Gardens Nursing Home Prince George's Lanham 8. Date of Birth (Month, Day, Year) Oct. 8, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2X F Months Days Hours 219-74-3549 83 Yrs. 1916 Director Usual Residence of Decedent filed within 72 hours efter deeth with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryle Department of Health and Meniel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show sup Injury or other treumatic event, the Medical Examiner must be notified at page. 1 Yes 2 □ No Directo Maryland Prince George's Bladensburg 10e. Street and Number 10g. Citizen of What Country? 4208 51st Street 20710 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elbert Dunlow Damron Maggie May Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4208 51st Street, Bladensburg, Maryland Donald L. Pumphrey - Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 5/08/2000 Brentwood, Maryland 22. Name and Address of Fecility ture of Fündual Service Licensee Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 or complications that caused the Approximete Interval Between Onset and Death n. Do not enter the mode of dying, such es cardiac or respiratory arrest, **Physician** tramediate Cause (Final disease or condition resulting in death) /Medical COMA Examiner Due to (or as a consequence of): Physician/Medical Examiner RAIN METASTASI ettending physician and d for use as the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): P.O. Box 68760. Metastalic Breast Due to (or es e consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? cete has been signed by page 2 should be detect 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No Pleural 1 ☐ Yes 2 ☐ No certificate Attending Physicien: funeral director. 8 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 25 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After To the Hospital or Attending within 24 hours effect deeth.

To the Funeral Director: Afte completely filled in by the fune 1 DNatural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cadifier M.D. 22549 110 04,2000

Registrar

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MAY 0 8 2000 DHMH 16 Rev 6/95

G.M. DIN 31. Date filed (Month, Day, Year) Kenilworth Ave Riverdale M.D. 20737

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6510

32. Registrar's Signature

WAY Do and Transfer

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth 3. Time of Death 5:16 A.M MARY , 2000 4c. County of Deeth 4e Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth Ft. Washington Hospital Ft. Washington Prince Georges If Under 1 Year if Under 24 Hrs. Months Deys Hours Min. 5. Sociel Security Number Birthplece (State or Foreign Country) 6 Sex 7. Age (In yrs. lest birthdey) Deys 1 M 2 TF Months 78 Yrs. 455-28-0278 Texas Usuel Residence of Decedent 10b. County 10e. Stete 10c. City. Town or Location 10d. Inside City Limits Maryland Prince Georges Ft. Washington 1 Yas 2 XNo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13304 Queens Lane 20744 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Maritel Status Bleck, White, etc. 1 Never Married 20 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fethar's Nama (First, Middle, Last) Eugenia Caldwell Luke T. Gore 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Elmer T. Perry/Husband same as item 10 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 5/5/2000 Alexandria, VA 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 21. Signature of uperel Service Licensee 22. Name end Address of Fecility George P. Kalas Funeral Home, P.A. 6160 0xon Hill Rd., 0xon Hill, MD 20745 shock, hear failure. List only one ceuse on each lina. Approximete intarval Between Onset end Deeth Immediata Cause (Finel disease or condition resulting in deeth) CORONARY HEART DISEASE

Due to (oras e consequence of): 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of daeth? 24a. Wes en autopsy performed? 1 Yes 1 □ Yes 2 □ No

Physician /Medical Examiner

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/Medical

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permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, the Medical Examiner ment be incited and once.

3altimore, Maryland 21215-0020

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Records, P.O. Box 68760.

Division of Vital

Physician/Medical Examiner

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Certification:

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To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medical

Registrar

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Part If, Other elgnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case raferred to medical exeminer? 26. Placa of Daath (Chack only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 28e. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturei 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be datermined 3 Suicida 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) 4 Homicide 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, data end place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the causa(s) end menner stated. 29a. Certifiar

30. Neroe end address of parson who complated cause of death (Itam 23a) (Type, Print) National Naval Medical Center, Bethesda, MD

29c. License number

12832-MISS

29d. Dete signed (Month, Day, Year)

31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

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32 Registrer's Signature

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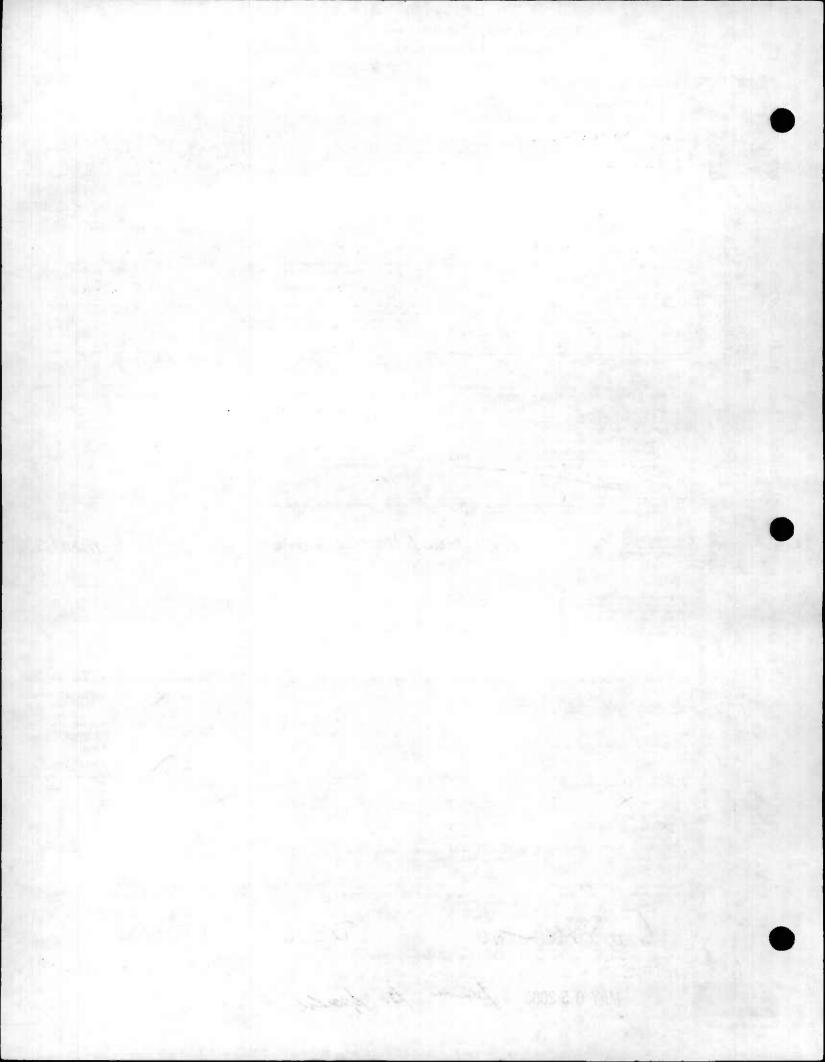
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** William L. Robbins, Sr. May 02 2000 2040 /Medical 4a Facility Nama (Il not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10146 Germantown Rd. Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Sept 28, 1910 Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2□F 212-18-6643 89 Yrs. Director MD Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 11 Yas 2 □ No MD Directo Worcester Berlin "natural", or items 23s or 25s-f edical Examiner must be notifie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10146 Germantown Rd. 21811 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status be filed within 72 hours after di ital Hygiene.
di other than "natural", or item event, the Medical Examiner. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 257 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chef Motel 12 permit. Papes 1 and 2 should be file Department of Health and Mental Hy important: If New 27 is marked other any Injury or other traumatic access 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 8 Riley Robbins Mary A. Smack 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulyne J. Robbins/wife 10146 Germantown Rd., Berlin, MD 21811 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1⊠ Buriat 2 ☐ Cremation 3 ☐ Removat from Stata 5/6/2000 New Bethel UMC Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Berlin, MD 21. Signature of For 22. Nama and Addrass of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 Approximata Intarval Betwaen Onsat and Daath 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Physician Metastabic Adenocarcinama /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): signed by the alid be detached for P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. P 24b. Wara autopsy findings available prior to completion of cause of death? should Completed 24a. Was an autopsy performed? has page 2 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa refarred to medical examinar? Be 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa Seasidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Aftert Certification: Attending Naturel To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Aftr To the Funeral Director: Aftr 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Cartifier edical (Check only one) 29c. License number 29b. Signatura and titla of certifier 29d. Data signed (Month, Day, Year) 30619 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 21811 Peter Abbott MD ty BIVO Berli 31. Data filed (Mon State

Registrar

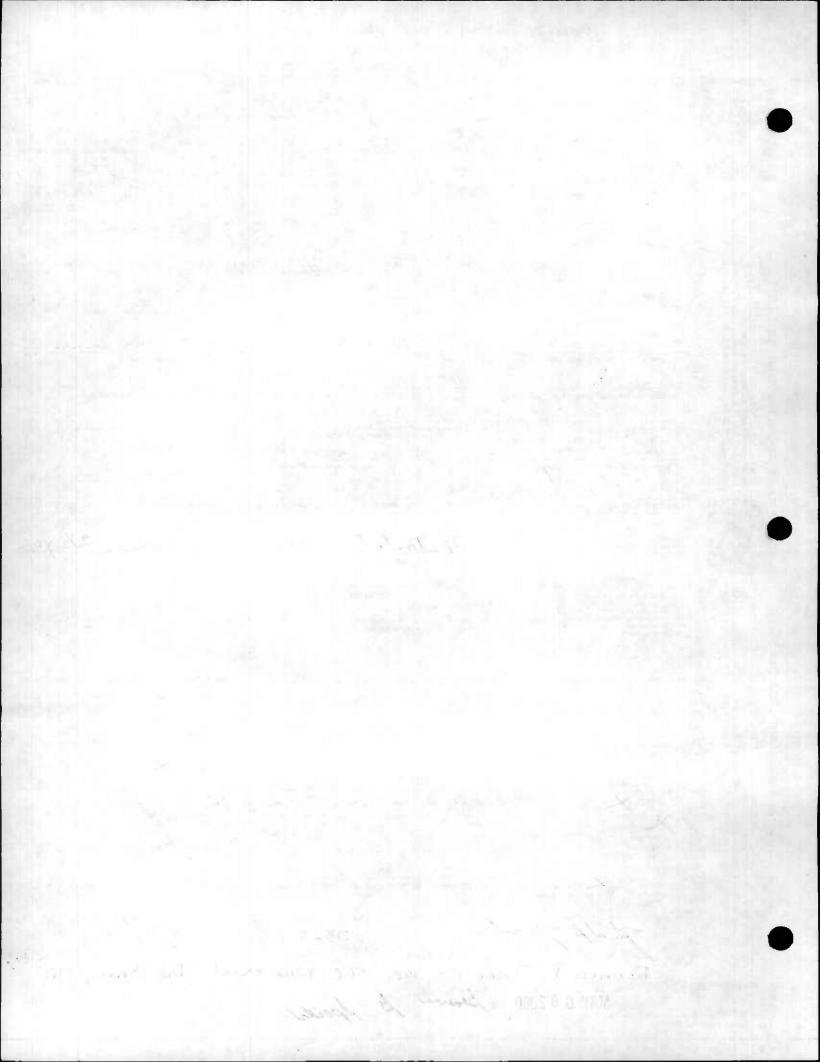


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician RUSSELL FRANKLIN RUARK May 6, 2000 11:05 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1004 Cecil St Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 19,1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** Months 12 M 2 ☐ F 215-18-4362 Yrs Director Maryland Usuel Residence of Decedent 10a, Stete 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico 1 DYes 2 □ No Salisbury Director 23e or 28e-f 10a Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 1004 Cecil St 21804 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or flams 11 Merital Status 14. Race - American Indian, Black, White, etc. 1 Ty Yes 2 □ No If Yes, Give Year or Detes: 1 Never Married 2 Married Army 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3X Widowed 4 ☐ Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Letter Carrier 12 US Postal Service Hed 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is to marked of Pages 1 and 2 should be Nelson J. Ruark Harriette Ellen Brown 10 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Department of Health and Important: If Item 27 is many injury or other traum Betty L. Carleton/Niece PO Box 63, Eden, MD 21822 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Removel from Stete 5/9/00 4 ☐ Donetion 5 ☐ Other (Specify) Pittsville Cemetery Pittsville, MD 21. Signature of Funeral Servica Licari 22. Name and Address of Facility Holloway Funeral Home Professional Association brune 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause of each line. Approximete tnterval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical tatie Colon 2/2 yrs Examiner Physician/Medical Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760. Due to (or as a consequence of) signed by the eld be detached for P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes SENO 3 Probably 4 Unknown p Records, 24b. Were autopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes No 1 ☐ Yes 2 ☐ No certificata Division of Vital Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this After thi funeral 27. Manner of Deeth
Naturel
2 Accident 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No hours after deat 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in 24 hour. 4 Homicide 6 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifie To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36576 HTIVASIL 2180 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Ruerriale 560 1 RAUITZ RONALD MO 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State MAY 0 9 2000

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Month 50 pm **Physician** 2060 LeShawn Octavia Riley lau 0 /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Paeth Examiner DOCTOR'S HOSPITAL Prince George's Lanham If Undar 24 Hrs. If Under 1 Yaar | Months Days Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) **Funeral** Hours Months 1□ M 25 F Director Washington, D.C. 578-06-0261 October 20,1969 30 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYas 2 No Funeral Director MD Pr 10e. Street and Number Prince George's Fort Washington 10f. Zip Code 10g. Citizen of What Country? 403 Dias Drive 20744 USA 14. Race - American Indian, Bleck, Whita, etc. 12. Was Dacedenf Evar in U,S. Armed Forces? 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Naver Merried 2 ☑ Married 1 Yas 2 No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Law Firm Legal Secretary permit. Peges 1 and 2 should be file.
Department of Heelth and Mental Hyg
important: If filen 27 is marked other
any injury or other traument 18. Mother's Neme (First, Middla, Maidan Sumama) 17. Fether's Nama (First, Middle, Last) Leslie W. Magruder Gwendolyn Knight 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 15307 Jennings Lane, Bowie, MD Gwendolyn Knight/Mother 20b. Plece of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/11/2000 Alexandria, VA Metropolitan Crematory 22. Name end Address of Facility 21. Signature of Funaral Sarvice Licensee OFDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Ave., Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Physician lar /Medical Immediata Cause (Final Metastatic lune cancer disease or condition resulting in deeth) Examine Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiate ceusa. Entar Undarfying Cause (Disease or Injury that initiated evants rasulting in daeth) Last Dua to (or as e consaquence of): Due to (or as e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2☑ No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performad? Completed 1 Yas 2 No 1 Yes 2 No 25. Was casa referred to medical axaminar? 8 26. Placa of Deeth (Check only one) 1 Yas 2 No Othar: 4 Nursing Homa 5 Residance 6 Othar (Specify) Hospital: edical Certification: To 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Dascribe how injury occurred 1 Netural 2 Accident 5 Pending invastigation 1 Yes 2 No 8 Could not be datermined 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - Al homa, farm, streef, factory, office building, atc. (Specify) 4 I Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at fha time, deta and place, and dua to tha causa(s) and mennar es steted.
2 Medical Examiner: On the basis of axaminetion and/or invastigetion, in my opinion, deeth occurred et the tima, date and place, and dua to the ceuse(s) and manner statad. 29a. Certifian 29b. Signeture and titla of certifier 29c. License number 29d. Data signad (Month, Dey, Year) 05-09-00 037391

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Division

To the Hospital or Attending

30. Nama and addrass of person who completed cause of deeth (Itam 23a) (Type, Print) 12/72 Central Ave #100 Mi) Central 31. Data filed (Month, Day, Year)

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22. Registrar's Signature

Mitchellville, MD 20721

1474 1 5 5 5000 S.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Aonth Yea CATheRINE Mai 4.30 am KOSS 2000 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Bradford Oaks 75 7520 Surratts Road Md. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Min 10 M 25 F Days Hours 577-16-7645 86 12/29/13 VA. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits YOS 2□No MD P.G. FT. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3508 Stonesboro Rd. 20744 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Account Officer Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Johnson Anna Johnson 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Marshall 3508 Stonesboro Rd.Ft. Wash. Md. 20744 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State DE Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 5/11/2000 Suitland, MD. 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Hodges and Edwards 3910 Silver Hill RD.Suitland, MD. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deet Immediate Cause (Final disease or condition resulting in deeth) nce of): Due to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

The law requires that the death certificate be executed

signed by to d be detach

certificate

this

within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral

director

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Be Completed

Certification: To

edical

Box 68760.

P.O.

Records,

Division of Vital

Hospital or Attanding Physician:

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permit. Peges 1 and 2 ahouid be filed w Department of Health end Mental Hygier Important: if item 27 is marked other th any injury or other traumatic avant, tha pncs.

Physician

/Medical

Examiner

Director

Completed

Be

Funeral

Director

il Hygiena. other than "natural", or thema 23a or 28a-f ahow vant, the Medical Exercites must be nouted as

death

Baltimore, Maryland 21215-0020

Physician/Medical Examiner attanding physician and for usa as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last

27. Manner of Death

1-Natural 2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

28a. Dete of Injury (Month, Day Year)

Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier LE Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner stated.

29d. Date signed (Month, Day, Year)

30. Name end address of person who comp ed cause of death (Item 23a) (Type, Print)

SSAN Branch Ane duton mo. 20735 P 1/aw 700 010 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

MAY 1 2 2000

5 Pending investigation

6 Could not be

28b. Time of Injury

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

MARLON ROGIERS	Flease	State of Marylan		of Health and I	Mental Hyg	_	7089				
the gardengerand.	1. Decedent's Name (First, Middle, Last	2. Date of Deal		3. Time of Death							
Physician /Medical	Marlon Glenfi 4a Facility Name (# not institution, give		rs	4b. City, Town, or	Month MAY Location of Death	3,2000 4c. County of Death	1. 43P.M.				
Funeral Director	6363 OXON HILL ROA		last birthday) If Under Months	OXON HII	8. Date of Birth	PRINCE GEO					
with the Maryland a or 28a-f show be notified at	10a. State 10b. County Md. Prince Ge		y, Town or Location er Marlbore	2			10d. Inside City Limits				
the N	10e. Street and Number	orges opp	10f. Zip			On Citizen of What Co.					
-0020 hours after death with the Marylend ural', or hame 23s or 28s-1 show LEvering must be nothed at		Drive 12. Was Decedent Ever in U, Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	20772 ent of Hispanic Origin? (S fy Cuben, Mexican, Puerl	U.S.A. 7 (Specify Yes or Nouerto Rican, etc.) Black 10g. Citizen of What Country? U.S.A. 14. Raca - American Indian, Black, White, etc. Specify: Black							
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d withi giene. r then	Elementary/Secondary (0-12)	College (1-4or 5+)	Teacher	, remouy		roge's Cty.					
Viand Vial be file Mental Hy mrked othe muc avant.	17. Fether's Name (First, Middle, Last)	Moses	Rogiers	18. Mother's Nar Hil	ne (First, Middle, I	Maiden Sumeme)					
, Mar and 2 sho alth and 127 is m	19a. Informant's Name/Relationship (7) Sandra E. Craft	rpe, Print) Wife			urel Route Number, City or Town, State, Zip Code) Upper Marlboro, Md. 20772						
altimore mit. Peges 1. partment of He portant: If item y Injury or oth	20a. Method of Disposition 1 Durial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	lace of Disposition (Name emetery, cremetory or of rthern Vir	e of her pleca) ginia							
pemit. Departminents any Injurence.	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 23. Name and Address of Fecility 24. Name and Address of Fecility 25. Name and Address of Fecility 26. Bocon CCO 36/W.H. Bacon FuneralHome 3447 14th St.N.W.										
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Clan: Trentificate sector, pa	25. Was case referred to medical			26 Piece of De	ath (Check only or		Yes 2 No				
hysician his central direct	examiner?	lospital:	ER/Outpatient 3 DO	Other:	lome 5 Reside		ity) HOTEL				
DIVISION OF VITAL RECORDS, P.O. BOX DOX To the Hospital or Attanding Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medical Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Dey Year) 28e. Plece of Injury - At he building, etc. (Specifi	28b. Time of Injury M	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,							
	29a. Cartifier 1 Certifying Phy	sician: To the best of my kno	wledge, death occurred a	it the time, date and place	City or Tow	ause(s) and manner as	stated. to the cause(s)				
the thin 2 the mplet	29b. Signature and title of certifier	and manner stated.		License number		9d. Date signed (Month					
F3F8	Atust A	Made	5 MP	O.C.M.E.		1AY 4,2000					
(2)	30. Name and address of person who con Stephen S. R.	adentz	111 P	enn Street,	Baltimor	re, Marylan	d 21201				
State Registrar	31. Date filed (Month, Dey, Year) MAY 1 2 2000	32. Registrar's Signa	ture box	the same							

Registrar DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

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Physician	ZETTA ROBERTS							2000	10:03 AM	
/Medical Examiner	4a Facility Neme (If not institution, gh HOLY CROSS HOSPI			4b. City, Town, or SILVER S		h 4c. County of				
Funeral Director	5. Social Security Number 5.78-18-9842 6.5	Sex 7. Age (In y. 1	M 2EF 91 Yrs. Months Days Hours Min. APRIL 10 1909 NORTH CAROI							
pu .	Usual Residence of Decedent 10a. Stete 10b. County	100	City, Town or Lo	ocation				10	d. Inside City Limits	
the Marylar 28a-f ahow nothed at	MARYLAND MONTGOME		1 → Yes 2 □ No							
\$ 0 B D	10e. Street and Number 8830 PINEY BRANCI	RY SI H ROAD #412		10g. Citizen of W		у?				
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Maryla d 2 should th end Mer T is merks traumetic	19a. Informant's Neme/Reletionship (Type, Print)	19b. Maili	ng Address (Stree	t and Number or R	lural Route Numb	er, City or Town, S	Stete, Zip C	Code)	
and 2 and 2 bath o	FRANCES RHONES/DAT	JGHTER	8830 1	PINEY BR	ANCH ROAD	SILVER	SPRING,	MD 20	0903	
Baltimore, North Pages 1 and Department of Health Important: If Nam 27 any Injury or other to page.	20e. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Special	ETERY	Date 20c. Location - City or Town, State 5-10-2000 BRENTWOOD, MARYL							
Baltim permit. Pag Department important: I any injury o	21. Signature of Funeral Service 1997 1997 22. Name and Address of Fecility FORT LINCOLN FUNERAL HO									
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Physician /Medical Examiner	Immediete Cause (Finet disease or condition resulting in death)	ACUTE TUBU		ROSIS					Onset and Death	
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58760, icate be executed physicien and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ASPIRATION	(or es a consec PNEUMON							
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Of Vita Physician: this certific ral director,	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA	her: 4 Nursing I	Home 5 ☐ Res	dence 6 Othe	r (Specify)		
Division of or Attanding Physical death. Director: After this in by the funeral death.	27. Manner of Death 1 Anatural 5 Pending 2 Accident Investigation		28b. Time of Injury	We	ry at ork?]Yes 2∐No	28d. Describe how injury occurred				
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Hospi 14 hours Funer Tely fill	29a. Certifier Certifying Ph Certifying Ph	ysician: To the best of my k niner: On the basis of exami end manner stated.	nowledge, death ination and/or inv	n occurred at the t vestigation, in my	ime, date end plac opinion, death occ	e, end due to the urred at the time,	cause(s) and mar date and place, a	nner as sta ind due to t	ted. the cause(s)	
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	1 Onet	ole		D199	971		MAY 5,	2000		
(6)	30. Name and address of person who KEMPANNA SUDHAKAR	7610 CARROLI			OMA PARK,	MARYLAN	ND 20912			
State Registrar	31. Dete filed (Month, Day, Year) MAY 1 1 2000	32 Registrar's Sig		Are V						

DHMH 16 Rev 6/95

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permit. Pages 1 and 2 should be fill Depertment of Health and Mantel Hy Important: if Nem 27 is marked oth any Injury or other treumatic event pages.

Physician

/Medical

Examiner

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I Director: After this certificated in by the funeral director, pages.

To the Hospital or within 24 hours eft To the Funerel Di completely filled in

Physician/Medical

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Division of Vital

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, mnmr State of Maryland / Department of Health and Mental Hygiene Dwayne M. Rouff AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth **Physician** May 16, 2000 Dwayne Maurice Rouff 935 am /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 6417 Livingston Road Apartment #101 Oxon Hill Prince Georges If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□ F Months 223-51-3075 26 Director Dec. 11, 1973 Virginia Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits -how r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 No 2 No Directo Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6417 Livingston Road #101 20745 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 Å No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. African within 72 hours effer 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

Elementery/Secondary (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) Samuel B. Rouff, Jr.

Help Desk Engineer Private 18. Mother's Name (First, Middle, Maiden Sumeme) Teressa M. McCoy

19a. Informant's Name/Relationship (Type, Print) Samuel B. Rouff, Jr. - Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 596 Peaksview Dr., Lynchburg, VA 24501

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funaral Service Ligat

20b. Place of Disposition (Name of cemetery, crematory or other place) 5/20/2000 Lynchburg, VA Forest Hill Burial Park 22. Nama and Address of Fecility

Stewart Funeral Home 20019 4001 Benning Rd., N.E. Wash., D.C. Approximate Interval Between Onset and Death

23a. Part. Entur the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, and present feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

20a. Method of Disposition

NARCOTIC INTOXICATION

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Dua to (or as a consequence of):

Due to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

20c. Location - City or Town, State

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 26. Place of Death (Check only one)

1 Yes 2 No

2 1 XYes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

25. Wes case referred to medical

5 Pending investigation 6 Could not be 28a. Date of Injury (Month, Dey Year) FOUND: 5-16-00 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? A FOUND: 1 Yes 2 No

Other: 4☐ Nursing Home 5 🂢 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred SUBJECT INGESTED DRUGS

> 28f. Location (Street end Number of Rural Route Number City of Town, State) 6417 LIVINGSTON RD APT. 101, OXON HILL, MD

29a Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and little of certifier

29c. License number O.C.M.E.

May 17, 2000

29d. Date signed (Month, Dey, Year)

me and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

RESIDENCE

State Registrar 31. Dete filed (Month, Day, Year) MAY 1 9 2000

HEUDORE MIKI

32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

se the burial-transit and set the burial-transit	ual Residence of Decedent a. State 10b. County Iryland Prince b. Street and Number 505 Suffolk Av Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Existence of Specify only highest gradiementary/Secondary (0-12) Father's Name (First, Middle, Last) Robert West a. Informant's Name/Relationship (Jackie E. Noland b. Method of Disposition 1 Naurial 2 Cremation 3 Chemical Secondary of European Secondary (0-12) Jackie E. Noland A Commant's Name/Relationship (Jackie E. Noland B. Method of Disposition 1 Naurial 2 Cremation 3 Chemical Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial 2 Cremation 3 Chemical Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial 2 Cremation 3 Chemical Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial 2 Cremation 3 Chemical Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial 2 Cremation 3 Chemical Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial 2 Cremation 3 Chemical Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial 2 Cremation 3 Chemical Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial 2 Cremation 3 Chemical Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial 2 Cremation 3 Chemical Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial Secondary (0-12) Jackie E. Noland B. Method of Disposition 1 Naurial Secondary (0-12) Jackie E. Noland B.	George's George's 1 M 2 DXF George's Ve., #313 12. Was Decedent E Armed Forces? 1 Dyes, Give Yeer or Dates: ducation ade completed) College (1-4or 5-	6 (In yrs. last bi 67 10c. City, Tov	inthday) If Un Mont In or Location Capitol 10f. 13. Was De If Yes, s 1 Ves. Decedent's L (Give kind of life. DO NO life. life. Do no life.	Ander 1 Year his Days L Heis Zip Code Recedent of I Specify Cut	Hours Min. 20743 Hispanic Origin? (Span, Mexican, Puerlo during most of word) 18. Mother's Nar	Peights 8. Date of Birth (Month, Da) Aug. 24 pecify Yes or No- o Rican, etc.) tking ne (First, Middle, Glady Journal Route Number	4c. County Prince Prince 1932 109. Citizen of V Unite 14. Race Blace Specify 16b. Kind of Bu Pr Maiden Sumemonthson	of Death Ce Geo 9 Birthpla Countr Vir 100 What Countr d Sta e Americar ck, White, et	ice (Stete or Foreign) ginia d. Inside City Limite 1 (A Yes 2 No. y? tes in Indien, ic. ck				
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29b.	. Signature and title of certifier				29c. Licens	se number		29d. Date signer	d (Month, Di	ay, Year)				
- 0	1 . 1	1 1/	1-1-	4	O.C.	M.E.	4	May 15	,2000					
1.00	Aturb A Vactory O.C.M.E. May 15,2000													
<	Name and address of person who	completed cause of de		(Typé, Print)	111 Pe	enn Stree	t, Balti	more, M	aryla	nd 21201				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JAMES CLAUDE STEPHENS MAY 5 2000 10:30 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3397 COULBOURN MILL RD SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. | 5. Sociel Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 11 M 2□ F 216-48-5530 55 Yrs. FEB. 10, Director 1945 MARYLAND Usual Residence of Decedent deeth with the Maryland 10e. Stete 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "naturel", or itema 23a or 28a-f aho I've Medical Examinar must be notified at 1 Yes 2 No Director |MARYLAND| WICOMICO SALISBURY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3397 COULBOURN MILL RD 21804 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: P WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementery/Secondery (0-12) College (1-4or 5+) OWN FARM FARMER permit. Pegas 1 and 2 should be filed to Department of Health and Mentel Hygie Importants: if item 27 is marked other the eny injury or other treumatic event, the page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN CLARK STEPHENS IRENE VIRGINIA GRAVENOR 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL D. STEPHENS - SON SALISBURY, MD 21804 3511 COULBOURN MILL RD 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) WICOMICO MEMORIAL PARK 5/9/00 SALISBURY, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 705 E. MAIN ST. 8/ SALISBURY, MD 21804 BOUNDS FUNERAL HOME, INC. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical Examiner Physician/Medical Examiner Pymonary attending physician and for use as the burial-transit that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last Diabetes P.O. Box 68760. Due to (or es a consequence of): signed by the a ld be detached for 23b. Did tobecco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 10 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24a. Was an autopsy page 2 2 No No 1 Yes 2N No 1 Yes certificate Division of Vital Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖺 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? edical Certification: 5 Pending Investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident by the 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicíde 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide 6 To the Hospital o within 24 hours af To the Funeral Di completely filled in

State Registrar

29a. Certifier (Check only one)

29b. Signeture end title of certi

30. Neme and address of perso

who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture

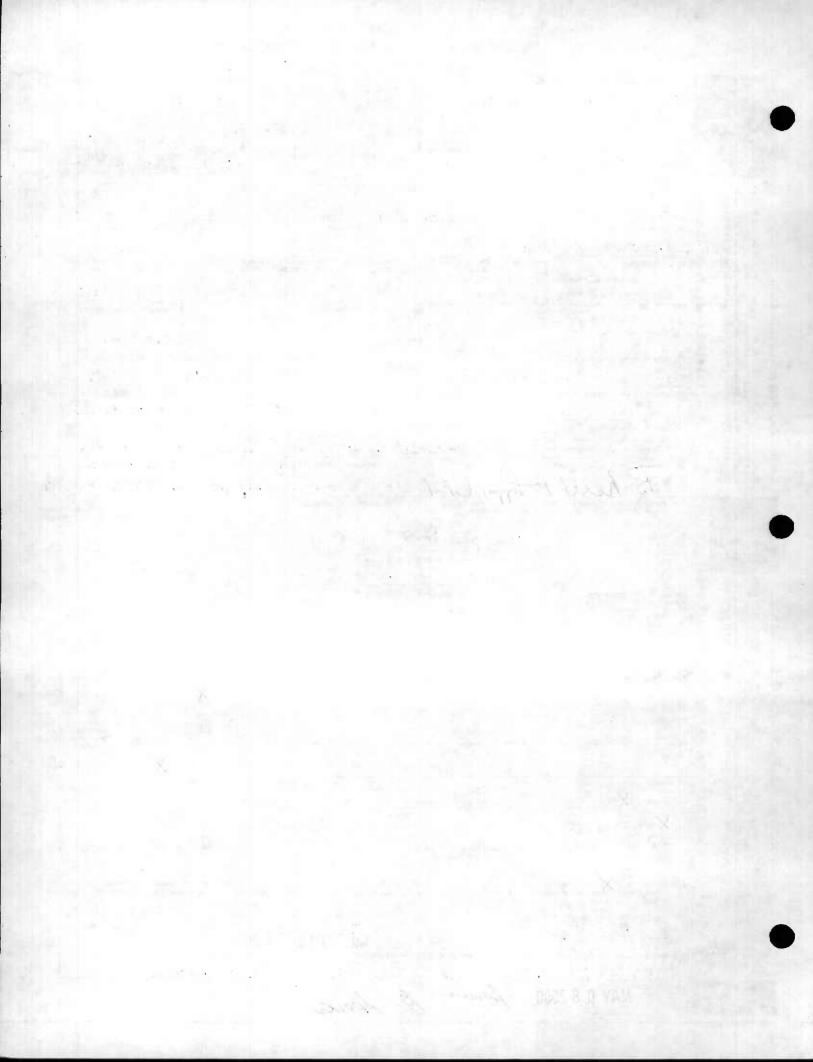
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

05-05-00



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

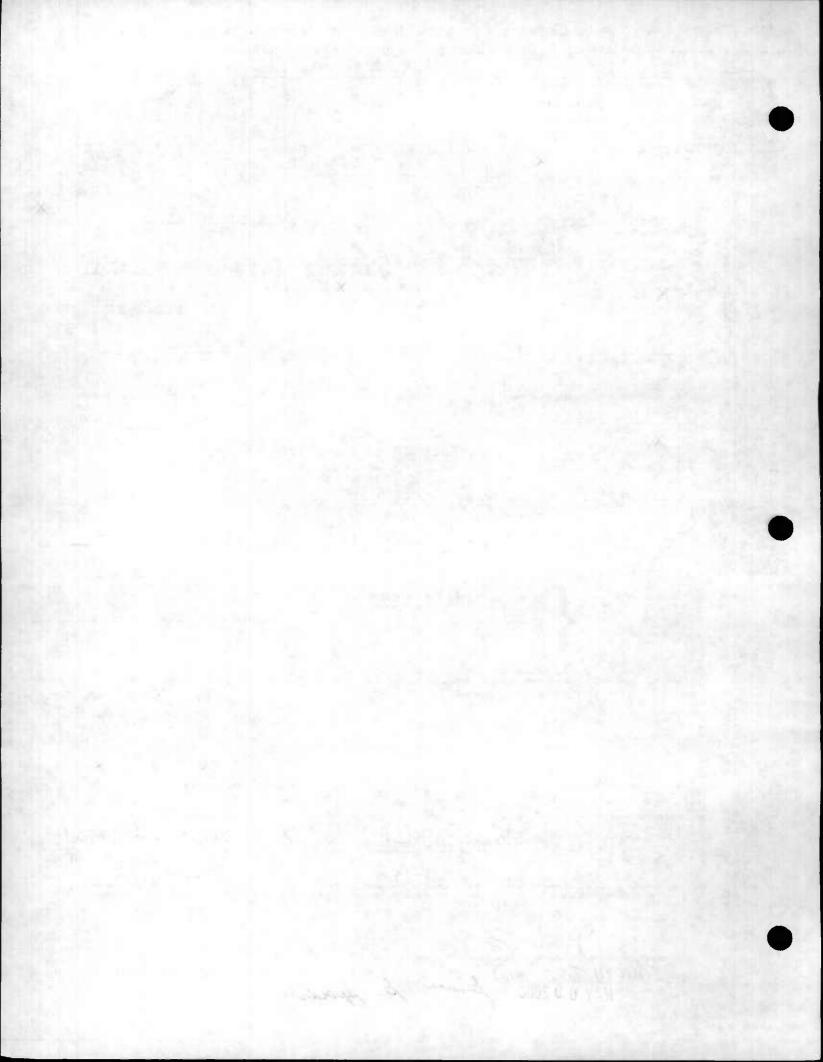
State of Maryland / Department of Health and Mental Hygiene WARREN SMULLEN JR. Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** 7:38 AM Warren Smullen MAY 6, 2000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** PENINSULA REGIONAL HOSPITAL SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer)

Jan.15 1943 Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours 1 MM 2□ F Yrs. 57 222-26-2953 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County raft, or items 23a or 28a-f show Examiner round be publied at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28664 Ocean Gateway permit. Pagas 1 and 2 should be filed within 72 hours aftar death to postument of Haalih and Mental Hypiena.
Important: If item 27 is marked other than "natural", or items 23a and hillury or other traumatic event, tra Medical Experies manages. 21801 U.S.A Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 22 No
If Yes, Give
Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: g 3 Widowed 4 □ Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Warren Smullen SR. Sophia Stanley 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. tnformant's Name/Relationship (Type, Print) Portia Smullen (Daughter) 28664 Ocean Gateway Salisbury, Md. 21801 20a, Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Springhill Mem.Garden Hebron, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 821 West Rd.Salisbury, Md. 21801 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com-shock, or heart teilure. List only ons that caused the death <u>Do not enter</u> the mode of dying, such as cardiac or respiretory errest, **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) **Examiner** Due to (or as e consequence of): Examiner physician and s the burial-transit death cartificata be axacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca ot): Box 68760. Physician/Medical Due to (or as a consequenca of): attending for usa as signed by the a 23b. Dfd tobacco use contribute to the cause of death? P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ☐ Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? paga 2 s Yes 2□ No 1 Yes of Vital 25. Was case reterred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatient 2 MKR/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) No Yes 2□ No To this funaral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Aftar Division or Attending 5 Pending investigation 1 Naturat 1 Yes 2 No 5/6/00 JUBIECT CUT AND STABBALL daath. Director: / 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 2965 OCENNEATE WAY 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 6 To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated. Home edical (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier O.C.M.E 7, 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Mil 111 Penn Street, Baltimore, Maryland 21201 32. Registers signature 9 2000

Registrar **DHMH 16 Rev 6/95**

State



	1. Decedent's Nam	ne (First, Middle	e, Last)	Certificate of Death						Reg. No.			Time of Death	
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	1 2 Burial 2	Cremetion		Removel from Stete 20b. Place of Disposition (Ner cemetery, cremetory or o				5 12						
eny injury or other traumatic avent, tra Ma page. To Be Compi	4 ☐ Donetion 21. Signature of Fi		DIRCOIN MEMORIAL						enkins Funeral H					
	7474 Landover RD													
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.										Inte	proximate erval Between set and Deeth		
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ni.	Ovarian Carcinoma									Y	<i>lears</i>			
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Completed									24a. W	es an autopsy riormed?	2	4b. Were e availeb	utopsy finding te prior to lion of cause	
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Be	25. Was case reference examiner?		Monitol:											
. To	1 ☐ Yes 2 ☐ 27. Menner of Deal			☐ Inpatient			SLI DOA	4 LI Nursing	Home 5 KR			Specify)		
tlon	1 Neturel 2 Accident	5 Pendin		Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No					28d. Describe how injury occurred					
Certification:	3 ☐ Suicide	6 Could r	nol be 28e. Pl	28e. Place of Injury - At home, ferm, street, fectory, office					28f. Location (Street end Number or Rurel Route Number,				ute Number,	
Sert	4 ☐ Homicide building, etc. (Specify) City or Town, Stell									own, Stete)	a)			
edicai (29a. Certifier (Check only one)	1 Certifying	g Physician: To Examiner: On the	the best of m	minetion end	death oc	curred et the tir tigation, in my o	ne, date end pla pinion, deeth oc	ce, end due to the curred at the time	ne cause(s) e e, date and p	nd menne tece, and	or es stated due to the	d. cause(s)	
M	29b. Signeture and	title of certifie		7			29c. Licens	e number		29d. Date	signed (M	fonth, Dey,	Year)	
	1	/	//-	20			D3:	1069		Ma	y 8,	2000)	
	1, 10 200								May 8, 2000					
1	30. Name and arts	uss of parmon	who completed o	ause of death	(Item 23a) (7	voe Prin	nt)							
Medical Certifi	30. Name and add	George					ile Lane	s Suite	⊇ 135 I	argo M	farer1	and		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 7 0 9 6 State of Maryland / Department of Health and Mental Hygiene

Live.		Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death									3. Time of Deeth		
Physician Medicai/	_	ISABELL	A F. SHO	LLENE	ER	GER		MAY	9, ^{Dey} 20	00 Yeer	9:50 PM		
/Medical Examiner	-	4e. Fecility Name (If not Institution, g.	ve street and number	er)			4b. City, Tov	wn, or Location of D		nty of Deeth			
	Ц	NATIONAL LU					ROCKV		TNOM	GOME			
unerai rector		218-24-3584	Sex 1□ M 25F	Age (In yrs. le		Months [Year If Under 2 Peys Hours	Min. 8. Date of (Month)	Birth Day, Year) 8,1912	9. Birth Cou PE	place (State or Foreign Intry) NNSYLVANI		
=	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town	or Location					10d. inside City Limits		
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		23a. Pert1. Enter the disease, of can shock, or heart failure.	plications that caus	ed the deeth.	Do no	enter the mode of	O- N SI dying, such es d	ardiec or respiretor	ASH., D	C	Approximate		
ian		SHOCK, or neart failure. Link sain	one cause on each	line.		,					Approximate Intervel Between Onset end Death		
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to		1 ☐ Maturel 5 ☐ Pending 2 ☐ Accident Investigatio	28a. Date of in (Month, D	ay Year)	Inj	y M	Injury at Work? 1 Yes 2 N		zo rion ngary coo				
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edical C		29a. Certifier (Check only one) 1 ☐ Certifying Ph 2 ☐ Medical Exar	ysicien: To the bes niner: On the besis end menner s	of exa <i>m</i> inetion	edge, o	eath occurred et the following in the state of the state	e time, date end ny opinion, deeth	place, and due to to occurred et the tim	he cause(s) end ne, date and plec	manner as s e, end due t	tated. o the ceuse(s)		
completely filled in by the fune. Medical Certification		9b. Signature and title of certifier	1-				cense number		29d. Dete sign	ned (Month,	Dey, Year)		
		Elver loge	1) / Car	rost	w	0	2172	-6	Mari	,10	2000		
	3	0. Name end eddress of person who	completed cause of	death (Item 2	3a) (T				1144	114	2000		
				9701-			, ROCK	VILLE, M	D.				
State	3	1. Dete filed (Month, Day, Year)	32 Flegis	trar's Signatur	0	0	,						

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Records, P.O. Box 68760, Division of Vital Attending Physician: After this death. Hospital or Attendi
 24 hours efter death.
 Funeral Director: A Within 2 To the

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician MAVIN G.STONE 5/10/2000 3:20 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner **CHEVERLY** PG PRINCE GEORGE'S HOSPITAL /NURSING HOME CENTER If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 2 (22) (143) Year) 9. Birthplace (State or Foreign NORTH) CAROLINA Funeral 1□M 2X F Director 579-16-1511 Usual Residence of Decedent with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits *how 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Director MARYLAND PG **FORESTVILLE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2008 OVERTON DRIVE 20747 Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. Black, White, etc. Never Married 2 Married Specify:BLACK 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event. The servent and page. Elementary/Secondary (0-12) College (1-4or 5+) 8TH GRADE NONE LABORER PRIVATE 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be UNK MARY STONE 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE STONE SAME AS 10A,B,C,D,E,&F 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 5/15/2000 ROCK CREEK CEMETERY WASHINGTON, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee #CC0273 JOHN T RHINES CO., INC. 3030 12TH ST NE, DC 20017 uan 23a Pirit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting In death) · ArTerioscherote Cardio VARWIAL Disage /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner ettending physician and for use es the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): the death certificate be exec that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown Klespiratory tailure þ 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy performed? Completed Encephalopally due to Avoxia Chronic Obstructive Lung Disease 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No filled in by the funerel 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ANatural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number Bullettore w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Queensbury Rd Hyattsville MD 2018/ DEVORE MO 4208C Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 2 2000

DHMH 16 Rev 6/95

Registrar

A ALCOHOL STORY A light of the state of the sta MAY 18 2000 See . M. M. Marine L.

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Physician	1.	20b. Per Fam.P Decedent's Name (First, Middle LUCILLE B.				rtificate of		2. Dete of De Month MAY	Peg. No. Day 6, 2000	Year	3. Time of Death
/Medical Examiner	40	LUCILLE B. Facility Name (If not Institution		4b. City, Town, or L							
ZX		REGENCY PARK	ASSISTED	LIVING		1907	GAMBRII	LLS	ANNE	ARUN	IDEL
Funeral Director	L	Sociel Security Number 488 18 5586	6. Sex 1 ☐ M 2 ☑	F	yrs. last birthdey) 80 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di March		9. Birthp Coun Mi	lace (Stete or Fore stry) SSOUTI
	-	sual Residence of Decedent Da. State 10b. County		10c	City, Town or Lo	ocation				1	0d. Inside City Lim
ural, or liens 23a or 28a-f show at Examinet must be notified at 5d by Funeral Director			Arundol								1 □ Yes ¾2 □
23a or 28a-f show ust be notified at rai Director	Maryland Anne Arundel Gambrills 10e. Street and Number 10g. Citizen of Whet C										ntry?
D P		2186 Hallmark Drive				2105	54		United States		
or Hems	11	1. Merital Status 1 Never Married 2 Marr	ried 1 TY	Decedent Ever i d Forces? 'es 2 ☑No s, Give or Dates:		Was Decedent of H If Yes, specify Cub	Hispenic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Race Black Specify:	k, White,	
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f Health and Mental Hygi ttem 27 is marked other other traumatic event, I	9	Samuel Roberts					Beula	ah Webb	er Webbe	r	
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Department of important: If eny injury or pace.	21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Robert E. Evans Fur 16000 Annapolis Rd.										715
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State of Maryland / Department of Health and Mental Hygiene 77799

Certificate of Death

Reg. No.

Raylor Sutton Raylor					Cer	tificate	of E	Death			Rec	ı. No.			
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Martiner of Southern Maryland Martiner of Southern Maryland South Security Number South	_	Raynor Sutto	n	,						April	25	,2000	· oui	2:45	P.N
8. Section Security Number 231—05-6615 Usual Recidence of Depoching Finance 1 231—05-6615 Usual Recidence of Depoching Finance 1 231—05-6615 Usual Recidence of Depoching Finance 1 100. Clearly 100. Clearly 110.	40	Facility Name (If not institution	n, give street and numb	oer)			46	b. City, To	own, or Lo	cation of De	ath	4c. County	of Death		
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20. Location - City or Town, State Device Concerning Concerning															
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Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.		2000													
Immediate Cause (Finel resulting in death) Due to (or as a consequence of):	2	23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart taken. List only one cause on each line. Approximate Intervel Between													
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) end manner es stated. 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end manner steted. 29b. Signature and title of chriser 29c. License number 29d. Dete signed (Month, Day, Year) May 2, 2000 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Norton A. Elson, M.D. 6525 Belcrest Rd. #208 Hyattsville, MD 20782		1 Natural 5 Pending		Injury 28						28d. Describ	e how				
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Norton A. Elson, M.D. 6525 Belcrest Rd. #208 Hyattsville, MD 20782	25	9b. Signature and title of deriffer	ton Else	n		29c. L	icense)203	362					Day, Year)	
31 Date filed (Month Day Veer) 22 Benistra's Signatures			The second secon	1 3 4 Mar 00	a) /Time !										
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			on, M.D. 65	25 Belci	rest			Hyat	tsvi	11e, M	ID 2	20782			

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death MAY 3, 2000 **Physician** 2:45 PM RUTH SILVA /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collington Life Care Nursing Home Mitchellville Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) Massachusetts 5. Social Security Number **Funeral** Months Days 1□ M 2₽ F Yrs. 89 026-28-1459 Director Usual Residence of Dacedant 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County 28a-fahow mant be notified at Mitchellville Md. Prince Georges YEYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 238 10405 Lottsford Road 20721 United States Funeral 12. Was Dacedant Evar in U,S Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amaricen Indian, Bleck, Whita, atc. permit. Peges 1 end 2 should be filed within 72 hours after d Department of Health and Mentel Hygiene. Important: If Item 27 Is marked other than "natural", or item any Injury or other traumatic event, ma Miscel Engine 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married White Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: à 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Georgia Anna Northrup John A. Hutchinson 19a. Informant's Neme/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3110 63rd Place, Cheverly, Md. 20785-3116 Marilyn Chase / daughter 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 Burial 2 Cramation 3 Removal from Stata May 4, 2000 Huntt Crematory Waldorf, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Fureral Sarvice Licensee 22. Name end Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd., Bowie, Md. 20 enter the mode of dying, such as cardiac or respiratory errast 20715 23a. Pert . Enler the diseese, or complications that ceysad the deeth. Do not shock, or heart failure. List only one cause on agch line. Approximata Intarval Between Onsat and Death Physician Immediata Causa (Final disease or condition rasulting in daath) /Medical Cerebrovascular accident 24 hours Examiner Dua to (or as a consaquance of) Physician/Medical Examiner 30 years Arterosclerosis or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immadieta cause. Entar Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last the burial-tran Dua to (or as a consequence of): and 30 years Peripheral Vascular Disease P.O. Box 68760, Dua to (or as a consequence of) Coronary Artery Disease 30 years Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contributs to the cause of death? 1 Yes 2 No 3 Probably 40 Unknown should be det Hypertension Division of Vital Records, by 24b. Wara autopsy findings available prior to Completed 24e. Wes en eutopsy performad? Hypercholesterolemia complation of causa of death? paga 2 1 ☐ Yes 2 No funerel director. Be 25. Was cesa rafarred to medical axaminar? 28. Placa of Death (Check only ona) Other: XXNursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) Medical Certification: To 1 Yas 2 No 1 | Inpatiant 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Neturel 5 Panding 1 ☐ Yes 2 ☐ No 24 hours after death. Invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, streat, factory, offica building, etc. (Specify) filled in by 4 Homicida Hospital 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and dua to the causa(s) and manner as stated. completaly (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 \$ 29b. Signetura and titla of certifier 29c. Licensa number 29d. Data signad (Month, Day, Year) D46834 May 4, 2000 30. Nama and addrass of person who complated ceusa of death (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

State

Mary Ruth Lopez

MAY 0 8 2000

31. Date filed (Month, Day, Year)

32 Registrar's Signatura

7525 Greenway Center Dr., Greenbelt, Md. 20770

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician VIOLA ADALINE. TULL AKA Violet A. Tull 8:45 AM 4b. City, Town, or Location of Death 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner Wicomico Salisbury Center: Genesis ElderCare Salisbury, MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 16,1902 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 M 2 TF 97 Yrs. Pennsylvania Director 214-52-0028 **Usual Residence of Decedent** 10s. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Directo Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 5 munt b 200 Civic Ave 21804 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours sher 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married ò 1 Yes 2 X No Specify: White Specify: à 3℃XVidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant; if Item 27 is marked oth jury or other traumatic even Be William Roach Julia (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dinah L. Neal/Niece 105 E. Fairfield Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 5/14/00 Salisbury, MD Parsons Cemetery 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association Molosi 501 Snow Hill Rd., Salisbury, MD 21804 (hompson 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (of as a consequence of). Examiner sician and buriel-iransii The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burie Box 68760, Physician/Medical Due to (or es a consequence of): signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown paron Tom Records, à 24b. Were autopsy findings eveilable prior to completion of cause of death? CARTURE RENTE Positive 24a. Wes en autopsy performed? Completed page 2 1 Yes 2 No 1 Yes 2 No of Vitai after death.

Director: After this certific d in by the funeral director, Physicien: 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division or Attanding 5 Pending investigation 1 []Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital or within 24 hours aff To the Funerel Di completaly lilled in 12 Conflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. edical 29a, Certifier 29b. Signature and title of continue 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

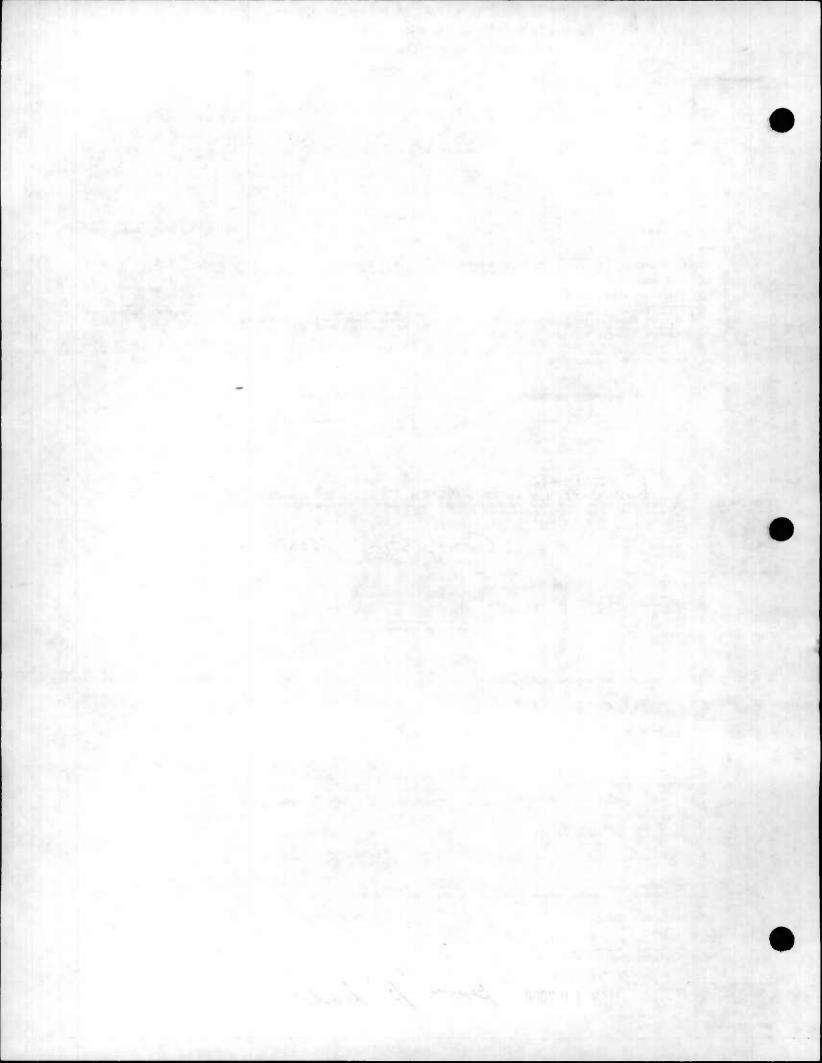
State Registrar MASKINS

31. Date filed (Mont)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2 Data of Death 3. Time of Death Month May **Physician** 10 Etta Mae Thomas 2000 9:35PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daeth Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Sept. 1, 1909 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** 1□M 2ŪF Days 90 Yrs. Virginia 137-05-8040 D Director Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 XYas 2 No Directo District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Brandywine St., S.W. 23a 20032 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yas 2 No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 11. Marital Status be flied within 72 hours after of lal Hygiene.

I other than "netural, or flee event, the Medical Examiner. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 DWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2.th College (1-4or 5+) Homemaker Private permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumeme) Be Fred Johnson Estelle Miller 19e. Informant's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian T. Archer - Daughter 50 Brandywine St., S.W. Wash., D.C. 20b. Place of Disposition (Name of cemetery, cremetory or other place) Cem. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal Irom State 5/15/2000 First Baptist Church Midlothian, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funerel Service Licenses Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Moul 23a. Part1. Antar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Daath **Physician** Immediate Causa (Final disaese or condition rasulting in death) /Medical SepticemiA -5-9-2000 Examiner Physician/Medical Examiner espivatory tailuve attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of): P.O. Box 68760. reumonia that initiated events resulting in death) Last Dua to (or as a consequence of): Clisecese reals Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown Records, À 24b. Wara autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy CARCINOMA weach History Hyperteusions 1 Yes 2/2PNo 1 Yas 2 No Division of Vital or Attending Physician: After this certifical funeral director, p 25. Was casa raterred to medical axaminer? 8 26. Place of Daath (Check only one) Hospital: 1 Schopation 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending investigation n 24 hours after deeth.

Ne Funeral Director: After pletely filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28I. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 T Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 042049 Meun 6. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) upper Marlbovo. Md-20772 CHAMPALOUX MD. G. 32 Registrar's Signature 31. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

MAY 1 2 2000

2 2000 S 2 1/AR

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Amnaj Taupradistha 07 05 2000 1:05 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10XM 2□ F Vre Director 4/19/40 Thailand 60 578-80-4054 Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location item 27 is marked other than "naturel", or items 23s or 28s4 show other traumetic event, the Medical Examiner must be notified at X Yes 2 No Capitol Heights, Maryland MD Prince Georges Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 111 Capitol Heights Blvd. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "naturel", or item eny injury or other traumatic event, the Medical Examinations. 1 ☐ Yes 2 ₹☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify. Specify: þ 3 ☐ Widowed 4 ☑ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bunnak Taupradistha Payoong Utradej 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Capitol Heights Blvd, Capitol Hts, MD 20743 Jitaree Taupradistha daughter 20b. Plece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/9/00 4 Donation 5 Other (Specify) Greenbelt, MD Chesapeake Crematory 21. Signature of Juneral Service Licer 22. Name and Address of Facility Pope Funeral Home 5538 Marlboro Pike, FV, MD mmon 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anoch, or heart feiture. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical intraventicular Examiner Due to (or as a consequence of) Physician/Medical Examiner pertension The law requires that the deeth certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Doe to (or as a consequenca of) and Division of Vital Records, P.O. Box 68760. physician the Due to (or as a consequence of) 88 ettending for use as 23b. Did tobacco use contributa to the cause of deeth? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 9 2 r this certificata has 2 DLNO 1 ☐ Yes 1 Tyes 2 No be or Attending Physician: The safer death.

I Director: After this certificated in by the funerel director, pe 25. Was case referred to medical Be 26. Plece of Death (Check only one) examiner? Hospital: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 TNo 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 DNaturel 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide • Funeral D letaly filled is Hospital 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner as stated. Medical pietaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature a 29c. License number D 00 54068 2000

sause of death (them 230) (Type, Pring!)

RTIG - Tinhice George Hospital

Maylandy

State Registrar 30. Name and address of person who completed

MAY 1 1 2000

LSe 31. Date filed (Month, Day, Year)

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32. Registrar's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Lillian I. Turner 3, 2000 4c. County of Death 11:50 PM MAY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death LAPLATA CHARLES CIVISTA MEDICAL CENTER | H Under 1 Year | H Under 24 Hrs. 8 Date of Birth (Month, Day, Year) | 9. Birthplace (State or roreign Country) | August 1,1916 | North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2₩F Months 246-24-9891 83 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Prince Georges Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 U.S.A. 12702 Halyard Place 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Å 14. Raca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Perry Turner Pearl Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Albert T. Turner/Son 12702 Halyard Pl. Ft. Washington, MD 20744 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removal from State Ft. Lincoln Cemetery May 9,2000 4 Donation 5 Dother (Specify) Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home o of Funeral Service Licens 3401 Bladensburg Rd. Brentwood, MD 20722 as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one Approximate Interval Between Onset and Deeth VANCED YERTPISTERAL VASCULARY immediate Ceuse (Finel disease or condition resulting in death) Due to (or as a consequence of): x Zwks. JANGYUEN OUS. Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably A Unknown 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Examine Box 68760 Physician/Medical å P.O. Records, p 3 Completed Division of Vital Be Certification: To Til. Affar Attending death after death Director:

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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or items 23a

natural',

e filed within at Hygiane.

permi. Pages 1 and 2 should be file Department of Haalth and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

Directo

Part II. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 25. Was case referred to medical 28e. Date of tnjury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. tnjury at Work? Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

A 24 hours Dis-Medical To the within 2 State

Registrar

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D - 20629

11345 PEMBROOKE SQUARE SUITE 103

00

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

M.D.

WATHEN

WALDORF MD.

MAY 0 9 2000

H.

29b. Signature end title of certifier

29a. Certifier (Check only

GEORGE

32 Registrar's Signature

MAY 0 9 2000 Street

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Yeer Month **Physician** 8:35 PM. 04 Stanley Whaley Jr.

4a Facility Name of not institution, give street and number) 24 00 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Baltimone University of Maryland Medical Center Baltimones 6. Sex 1 M 2 □ F If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) O9 / 11/1970 9. Birthplece (State or Foreign Country) Delaware 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 29 Director 213-98-7815 Usuel Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Baltimore City Baltimore Name 23a or 25a-f 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 2845 Calvert Street 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Maritel Stetus a Hygene. d other than "natural", or hema event, the Medical Examiner, 1 Yas 2 No If Yas, Giva Yeer or Dates: 1 Never Merried 2 Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grede complated) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry the filed within Elementery/Secondery (0-12) College (1-4or 5+) Highway Safety Service 12th crew foreman Maryland permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If Item 27 is marked other any figury or other trausments of the pages. 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Surname) Mollie B. Purnell Stanley Robert Whaley, Sr. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 2845 Calvert Street, Baltimore, MD 21218 Melissa Zabor-Whaley/wife Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other piece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 XBuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Paul UM Church Ceme. 4/29/00 Berlin, Maryland 21. Signature of Funerel Service Licenses 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD lley Jolley Memorial Chapel 21801 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Interval Batween Onset and Deeth **Physician** /Medical Immediate Ceusa (Finel diseasa or condition rasulting in death) PRIMITIVE Neural Ectodermal Bosin Tumor Examiner Due to (or es e consaguance of): The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medicai the th Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Aspiration Preomonia Completed by 24b. Wera autopsy tindings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? Intraventricular Hemorrhage this certificate has 1 Yas 2) No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 100 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Medicai Certification: To luneral 28d. Describe how injury occurred s after death.
It Director: After the 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending invastigation Division 1 Neturel 2 ☐ Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D completely filled is to Certifying Physician: To the best of my knowladge, daeth occurred et the time, date end pleca, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, deta end plece, and due to the ceuse(s) end menner steted. 29a, Certifier (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) Resident Physician P13355 36 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University of Manyland. Michael Akom MD, 22. S. Greene St. Baltinese, MB 21202 31. Deta filed (Month, Day, Year)

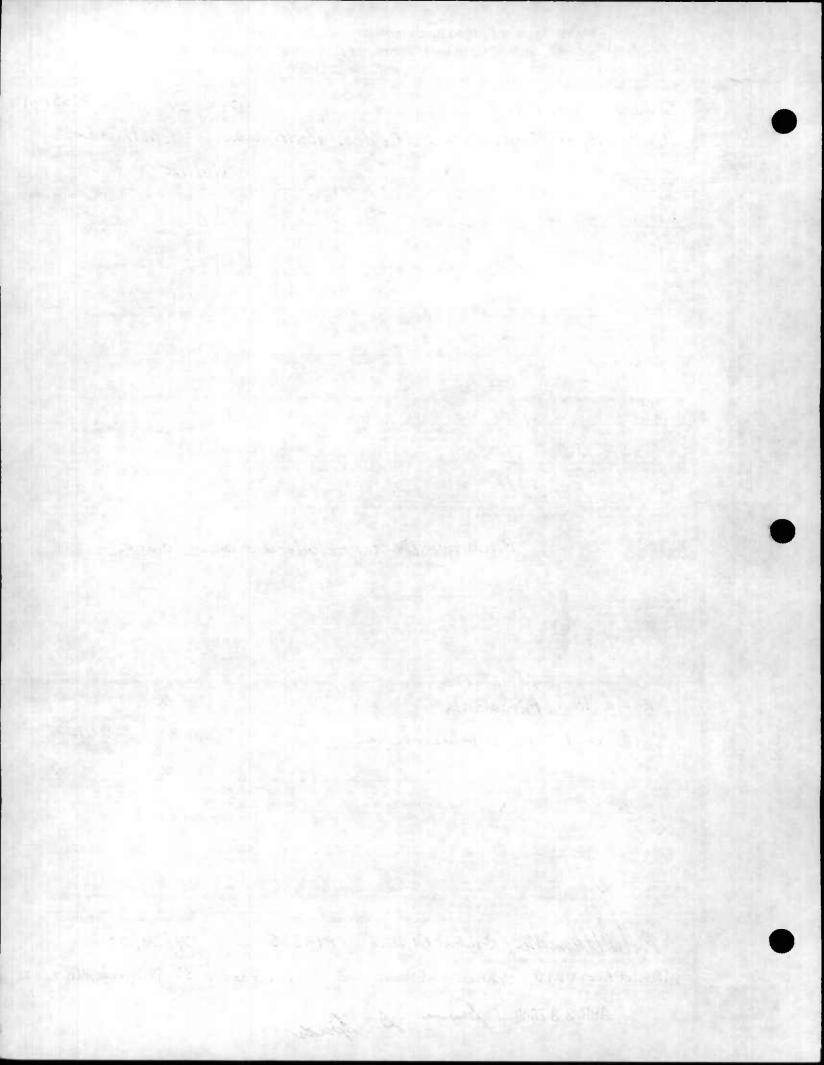
State Registrar

DHMH 16 Rev 6/95

D. Sparks.

ORIGINAL

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Ohn 100 0241 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) August 16,1926 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country) Pennsylvania 6 Sex 7. Age (In yrs. last birthday) Days 10 M 2□ F 202-14-9956 Yrs. 73 Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pittsville 1 ☐ Yes 2 ☑ No Wicomico Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21850 7955 Pittsville Rd 12. Wes Decedent Ever in U,S.
Armed Forces?
1 12 Yes 2 □ No
If Yes, Give
Year or Dates: Kone Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Bleck, White, etc. WW II 1 Never Merried 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Korea White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) GNB Inc. Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Eva Cymbalak Frank T. Wagurak 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7955 Pittsville Rd., Pittsville, MD 21850 Norma E. Wagurak/Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place 20a. Method of Disposition 20c. Location - City or Town, Stete 1 □XBurial 2 □ Cremetion 3 □ Removel from State Springhill Memory Gardens 5/9/00 Hebron, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Neme and Address of Fecility Holloway Funeral Home Professional Association stune 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset end Death ears 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown nalmia 1 Yes 2 No 24e. Wes en eutopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filled within 72 hours after c. Department of Health and Mentel Hyglene. Important: if New 27 le marked other than "naturel", or than any injury or other traumetic event, the Medical Exercities page.

Baitimore, Maryland 21215-0020

death

Physician/Medical Examiner þ Be Completed

The law requires that the deeth certificate be executed the buriel-tran P.O. Box 68760, ate has been signed page 2 should be de Records, cartificate Division of Vital or Attending Physicien: funeral director. After this n 24 hours after death.

• Funeral Director: After the further than the fu Hospital within 24 hor To the Fune completely li \$

7+IVA SIC

Registrar

29b. Signature and title of certifie

MSMA

31. Dete filed (Month, Day, Year)

MAY 0 9-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMID

32. Registrar's Signature

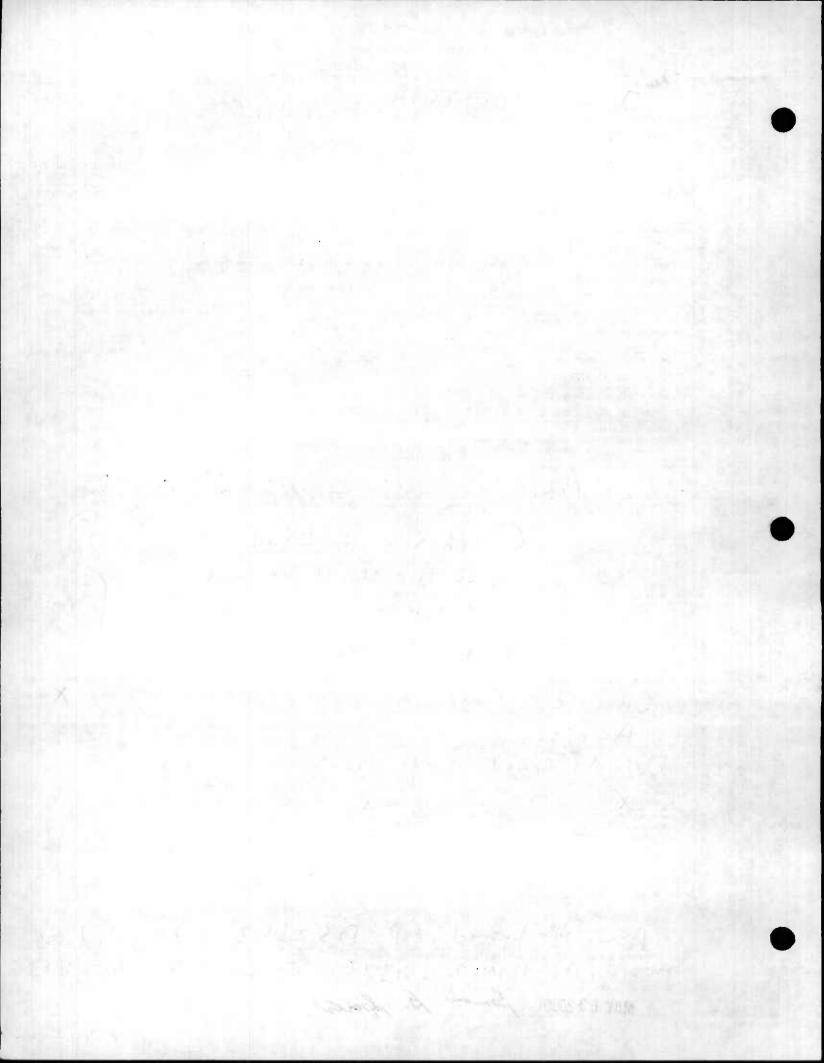
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24b. Were autopsy findings available prior to completion of cause of deeth? rinaly 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending 1 Natural 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29e. Certifier Medical (Check only one)

DHMH 16 Rev 6/95

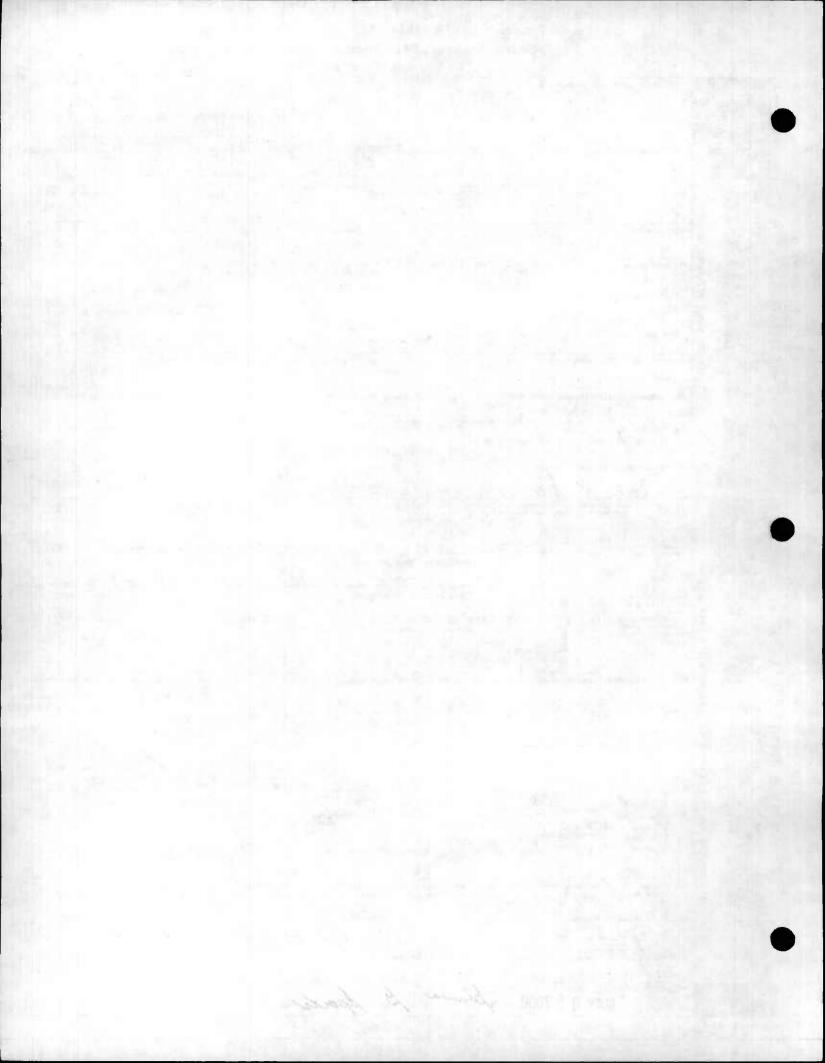
29c. License number

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			State of Mar		ertificate of			Reg. No.	1/10/
	Dhysleinn	1. Decedent's Name (First, Middle, Li	ist)			Miles I	2. Date of Dec		3. Time of Death
	Physician /Medical	DAVID	WILSON	WEAV	ER JR		May 7		1:20 AM
	Examiner	4a Facility Name (If not institution, gl	ve street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of	Death
		31947 Rushmore I		- 11 11 17		Parsonsb	urg	Wice	omico
	Funeral Director	219-62-7983	Sex 7. Age (In yrs. lest birthday 45 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Augus	t 5,1954	Delaware
1	t.	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits
	or 18e-f show be notified at Director	Maryland Wicom		1 ☐ Yas 2					
-	23e or 28e-f	10e. Street and Number 31947 Rushmore I	Orive		10f. Zip Code 21849			10g. Citizen of Who	at Country?
Maryland 21215-0020	Samper m	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U,S. 13.	Was Decadent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yas or No- Rican, etc.)	Black,	American Indian, White, etc. White
200		15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usuel Occup a kind of work done	pation during most of work d)	ing	16b. Kind of Busin	ness/industry
121	pan de Man	Elementary/Secondary (0-12)	College (1-4or 5+)						
2		12 17. Father's Name (First, Middle, Last	4	Coord	inator voca	tional train	-	Blind] Maiden Sumame)	Industries
an	a sess		Weaver Sr.			Celest			
2	To To	19a. Informant's Name/Relationship		10b Mail	ing Address (Ctreat	and Number or Rura			ata Zin Cada)
Ma	7 8 2 2	Nancy L. Weaver/	Wife						
	216	20a. Method of Disposition	wite	20b. Place of Disp	osition (Name of	ore Dr.,	Parsons Date	20c. Location - Ci	
OF.	mt: # ib	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont			metory or other ple		E /11 /00	** 1	1475
altimore	THE .	21. Signature of Funeral Service Lice			1. Memory Ga 2. Name and Addre		5/11/00	Hebror	I, MD
m i	Dep	> Keith R. K	burees		Holloway 501 Snow	Funeral He Hill Rd.,	Salisb	ury, MD 2	l Association 21804
	-	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not en	iter the mode of dyin	ng, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between
	hysician /Medical	large effects Course (Fig. 1)							Onset end Death
100	xaminer	Immediate Cause (Finat disease or condition resulting in death)	. METASTATO	LIVER	DISEASE	FROM GA	STRK (ARCINE MY	ic 8 men.
			Do	e to (or as a conse	quence of):				
3	- HE		b. CESTRUCTIVE	E JAUNOS e to (or as a conse		(BD S	TRICTUR	£	CHENOWN
68760,	physician and sithe burdelmansit and cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury							
68760,	physicia s the bur edical	I ned kunden eacht?	c. SEIZURE	e to (or as a conse	Υ				UNKNOWN
	D 0	resulting in death) Last		e to (or as a conse	quence or).				
Вох	nipu n		d A				_		1
m =	d by the ettending ettached for use	Part II. Other significant conditions of	contributing to death but a	not resulting in the	underlying cause oil	en in Pert I	23b. Dld I	ohacco use contr	ibute to the cause of death?
P.O.	thy thy						10	/	□ Probably 4 □ Unknown
S, F	be de								
of Vital Records, P.O. Box								an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
B E	e has						101	res 20 No	1□Yes 212No
ta	s cartificate he director, page To Be Com	25. Was case referred to medical				26. Place of Deatl		A	.5.00
of Vita	Il direc	axaminer? 1 Yes 2 No	Hospital:	2 ER/Outpatie	ent 3 DOA Oth	nor:	/	lence 6 Other	(Specify)
	er th	27. Manner of Death	28a. Date of Injury (Month, Day Y	(ear) 28b. Time (of 28c. tnju	y at	28d. Describe h	now injury occurred	
Vision	death. ctor: Afr y the fur ficatio	1 2 Natural 5 Pending 2 Accident investigatio	n	,		Yes 2 □ No			
- >	atter death. I Director: After to in by the funeral Certification:	3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
Josephal	within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral of Medical Certification: To	(Check only 2 Medical Exam	nysician: To the best of miner: On the basis of ex						
-	Med Med	one)	and manner state		29c. Licens			29d. Date signed (
P	\$ P 8	29b. Signature and title of certifier	0						
						929		6-8-	
123	de	30. Name and address of person who				T Stir	MA	218011	
	State	31. Date filed (Month, Day, Year) MAY 0 9	32. Registrar's	Signature	6 10/014 0	· SALIS.	inco	21004	
	Registrar	31. Date filed (Month, Day, Year) MAY 0 9	2000	eva /	. spar	K			



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death May **Physician** ADRIENNE PATRICIA WILKERSON 2000 09 0951 /Medical 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Malcolm Grow AAFB Hospital Prince George's Camp Spring If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Months Deys Hours 1 M 2 F 577-54-5845 59 Director January 25,1941 Washington, D.C. Usual Rasidence of Dacedant the Manylend 10a. Stata 10c. City, Town or Location 10d. Inside Clty Limits ahow r Nema 23a or 28a-f ahov iner must be notified at 1 X Yas 2 No Washington, D.C. Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 1457 Ridge Place, S.E. 20020 U.S.A. Funeral death 14. Race - American Indian, Black, White, atc. 12. Wes Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) or Nerna 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or from any injury or other traumatic event, the Medical Experimental and 1 Yas 2 XNo If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Postal Worker 5+ Government 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be Julian James Wilkerson Hattie Carter Mae 19a. Informant's Name/Ralationship (Type, Print) Daughter 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 5509 Windsor Drive, Temple Hills, Maryland 20748 Kimberly R. Scott-Robinson/ 20b. Place of Disposition (Neme of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 Removal from Stata Cedar Hill Cemetery 2000 4 Donation 5 Othar (Specify) Suitland, Maryland 21. Signature of Furniral Sarvice Licensee 22. Name and Address of Facility
J.B. JENKINS FUNERALHOME 7474 Landover Road, Landover, Maryland 20785 Fart I. Enter the disease, or complications that caused the death. Do not anler the mode of dying, such es cardiac or respirelory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Adenocarcinoma Of Lungs Examiner Due to (or es e consaquance of): Physician/Medical Examiner The lew requires that the death certificate be executed Sequantially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disaase or injury that initiated evants resulting In death) Last for use es the burial-tran Dua to (or as a consequence of): P.O. Box 68760. Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown Cardiomyopathy Records, b director, page 2 should be 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy Valvular Heart Disease 1 ☐ Yas 2 ☐ No 1 Yes 2 X No certificate of Vital or Attending Physician: 25. Was case raferred to medical 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this funeral 27. Mennar of Death 28b. Tima of 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Division After 1 X Natural 5 Pending after death. 1 ☐ Yas 2 ☐ No Investigetion 2 Accidant the ne Hospital or Attanta 24 hours aftar der ne Funeral Director pletely filled in by the 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medicai 29a. Cartifiar completely (Check only To the Within 2 To the 29tr Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D-31173 May 10, 2000 Ralph Nelson, M.D., 1160 Varnum Street, N.E., Suite #208, Washington, D.C. 32 Registrer's Signeture 31. Date filed (Month, Day, Year) State MAY 1 2 2000 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Rebecca Watts 2000 11:42Ar 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Beath Examiner CATON MANOR GENESIS ELDER CARE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | 9. Birthplaca (Stata or Foreign Months | Days | Hours | Min. | Apr. 19, 1912 | South Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 549-56-0700 1□ M 2X F Months 88 Yrs. Usuat Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits Yas 2 No Maryland | Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4410 Oglethorpe St. #301 20781 United States 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7th Beautician Self-Employed 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar Hill Carrie Lockhart 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Richardson - Niece 1806 Thomas Ave., Baltimore, MD 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 5/15/2000 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service License 4001 Benning Rd., N.E. Wash., D.C. 23a. Part Littler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death tramediate Cause (Final disease or condition resulting in death) Electrolyte Imbalance Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yea 2 No Instructive polymoney 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 400 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending investigation 1 TYas 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Records, P.O. Box 68760 Division of Vital al or Attending Physics after death.

N Director: After this ed in by the funeral d

Physician

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Manylan Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic avent, the Medical Exercitors must be notified at

Physician

/Medical

Examiner

attending physician and Hor use as the buriel-transit

be det

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Physician/Medical

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Completed

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Medical Certification:

29a. Certifier (Check only one)

EBECCA

/Medical

Director

To the Hospital or A within 24 hours after To the Funerel Direct completely filled in b.

Registrar

30. Name and address of person who comp DR. OCHANEY 31. Date filed (Month, Day, Year) MAY 1 2 2000

29b. Signature and title of certifie

32 Registrar's Signatura

D-40521

29d. Date signed (Month, Day, Year) 6005,01

Hed couse of death (Hom 23a) (Type, Print) 3350 Wilkens Avenue Suite 302 Bathmare, MD 21229

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Death CHARLES J. WRIGHT 09, MAY 2000 11:30 A.M.

4b. Cify, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

PRINCE GEORGE'S

Physician
/Medical
Examiner

4a Facility Name (If not institution, give street and number)

Malcolm Grow Medical Center

Funeral Director

Baltimore, Maryland 21215-0020

Examiner

Physician /Medical

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 16 Rev 6/95

ANGELA

31. Date filed (Month, Day,

2000

	5. Social Security Number	6. Se	ex .	7. Age (In yrs	. last birthday)		er 1 Yee			B. Dete of Bir	th	9. Birthplaca	(State or Foreig
	225-12-4098	1]	ØM 2□F	79	Yrs.	Months	Day	Hours	Min.	JUNE	28,1920	CULPE	EPPER, VA
	Usual Residence of Decedent		11		*	1	-						
	10a. Stete 10b. Coul	nty		10c. C	ity, Town or Lo	ocation						10d. l	nside City Limit
to	MD PRIM	NCE C	GEORGES	S	UITLANI)							NYes 2□N
9	10e. Street and Number		JEONOLI	, ,	O I I IMINI	_	ip Code				10g. Citizen of V	What Country?	
ō	1922 PORTER A	AVE						746					e c
Funeral Director		1417	12 Was Das	cedent Ever in I	IS 12	Was Doo			nin? /Sna	city Vac or No		D STATE	
Ľ	11. Marital Status		Armed F	orces?	0,3.	If Yes, sp	ecify Cu	Hispanic Original, Mexicen	, Puerto F	Rican, etc.)	Blac	k, White, etc.	TOTALI,
d by F	1 □ Never Married 2 □ XV 3 □ Widowed 4 □ Divorce		If Yes, G Year or I	2 No ive Dates:		1□ Yes	2 🗆 📉	Specify:			Specify		
etec	15. Deced (Specify only hig			,	16a. Dece	dent's Us	uel Occi	upation e during most	of working	00 1	16b. Kind of Bu	usiness/Industr	У
Completed by	Elementary/Secondary (0-12			(1-4or 5+)				e during most ed) PERATO			U.S. A	AIR FOR	CE
0	17. Father's Name (First, Midd	lle, Last)	- 7 -		100			18. Mothe	r's Name	(First, Middle	, Maiden Sumer	ne)	
o Be	FRANKLIN PRE	ESSLE	Y WRIG	ЭНТ				МАБ	RY TH	OMAG			
10	19e. Informant's Name/Relation			7111	10h Maili	no Addro	ee /Stra				er, City or Town,	State Zin Cov	(0)
	PHYLLIS W. BU			TICHTED	101								
	20a. Method of Disposition	JICILIE	IL / DE		Plece of Disp			FORT F	LACE	Date	WASHING 20c. Location -		
	1 Burial 2 Crematic	on 3 🗆 F	Removal from		cometery, cre	metory or	other p	lace)		Date	20C. LOCATION -	City of Town,	State
	4 Donation 5 Other	(Specify))		HARMONY	MEM	ORIA	AL PARK	5	-16-00	LANDOV	/ER,MD	
	21. Signature of Figure 1 Servi	grions.	re h		2						RAL HOME		7
	23a. Part1. Enter the disease.	or comp	lications that	caused the des	ith. Do not en								proximate
	shock, or heart feilure. I Immediate Cause (Final disease or condition resulting in death)	List only o		G CANCE	R						16.7	On	erval Between set and Death
h				Due to	(or as a conse	quenca o	f):					i	
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X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			Due to	or as a conse	quenca of	f):						
al E	Cause (Disease or Injury	2	6.										
음	that initiated events resulting in death) Last	1		Due to (or as a consec	quence of):					į	
ž	and the second second	L	d									į	
an									19				
얆	Part II. Other significant cond	litions co	ntributing to d	death but not re	sulting in the u	ındertying	cause	given in Part I.		23b. Did	tobacco use co	ntribute to the	cause of death
F,										12	Yes 2 No	3 Probabl	y 4 Unkno
þ		-											
petel											s en autopsy ormed?	availat	autopsy findings ble prior to etion of cause th?
Comp										10	Yes 2 No		s 2 No
Be	25. Was case referred to med examiner?	ical						26. Place	of Death	(Check only	one)		
0	1□ Yes 2⊠No		Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 (DOA	her: 4 Nu	rsing Hor	ne 5 Res	idence 6 DOth	er (Specify)	
ë	27. Manner of Death	2013	28a. Date	of Injury oth, Day Year)	28b. Time o	of	28c. In	jury at	2	28d. Describe	how injury occur	red	
Ho	1 Matural 5 ☐ Pen 2 ☐ Accident inve	estigation		nn, Day roar,	Injury	М		Yes 2 1	No				
edical Certification: To Be Completed by Physician/Medical Examiner	3 Suicide 6 □ Cou	ald not be ermined	286. PIGC	e of Injury - At I ling, etc. (Spec		reet, facto	ory, offic	е	2		(Street and Numb wn, State)	per or Rural Ro	oute Number,
dical C	29a. Certifier 1 Certification Check and 2 Medicate	lying Phy cal Exami	iner: On the b	esis of examin	owledge, deal etion and/or in	h occurre	d at the	time, date and opinion, deet	d plece, a	and due to the	cause(s) and me , date end pleca,	enner as stated and due to the	d. cause(s)
ě	non risearch Advance of one	A.m.	and man	ner steted.			On Line	nee number			20d Date signe	d /Month Day	Voer

MC

CAPT, USAF,

MD D0052533

of death (Item 23a) (Type, Print) 89 MDG/1050 W PERIMETER RD

MAY 09, 2000

ANDREWS AIR FORCE BASE, MD 20762-6600

COUNTY TO THE TOWN IT YOU

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Yaar Kent Randolph Wright 12:07 PM 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors' Community Hospital Prince George's Lanham 9. Birthplaca (Stata or Foraign H Under 1 Yaar 6. Sex 1 M 2 □ F 5. Social Security Number If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 13, 1 7. Age (In yrs. last birthday) Months Days Hours 577 15 8618 Yrs. 44 1955 Colorado Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits ₩XYas 2 No N/A Washington D.C. S.W. 10e. Street and Number 10f. Zip Coda 10g Citizen of What Country? 605 4th S.W. 20024 United States 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian Black, White, atc. 12. Wes Decedent Ever in U.S. Armed Forcas? 11. Marital Status 1 Yas 2 No
If Yes, Giva
Year or Datas: Nevar Married 2 ☐ Married 1 ☐ Yas 20XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Collega (1-4or 5+) Elementary/Secondary (0-12) Numismatist Coin Dealer 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) James Wright Lottie Watanabe 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 605 4th S.W. Washington D.C. Wright Father James 20a. Mathod of Disposition
1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from Stata 20b. Place of Disposition (Nama of camatary, cramatory or other place) May 12, 2000 20c. Location - City or Town, State Waldorf Maryland 4 ☐ Donation 5 ☐ Othar (Specify) The Huntt Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 21. Signeture of Funerei Service Licen 16000 Annapolis Rd. Bowie Maryland 20715 Part 1. Enter the disease, or complications that/caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onsat and Death Immediata Causa (Final diseasa or condition rasulting in daath) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the undarlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to NA

Physician /Medical Examiner Examine

physician end s the burial-transit

Physician/Medical

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Completed

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the death certificate be executed

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To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completaly filled in by the fu

Records, P.O. Box 68760,

of Vital

Division or Attending **Physician**

/Medical

Examiner

10a. Stata

N/A

Director

Funeral

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Completed

Be

10

Funeral

Director

WOU!

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any Injury or other treumatic event, the Medical Examina any Injury or other treumatic event, the Medical Examina pines.

Baltimore, Maryland 21215-0020

death v

Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarfying Cause (Disaase or Injury that inflated avents rasulting In death) Last

1 Yas 2 No

27. Manner of Death

1. Natural

2 Accidant

4 Homicida

3 ☐ Suicide

	The Author	
25. Was casa rafarred to medical examinar?		26. Placa of Death
THE PROPERTY OF THE PROPERTY O	 	

1 Inpatiant

28a. Data of Injury (Month, Day Year)

1 Yes

26. Placa of Death (Check only ona)

1 Yas 2 No

Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28d. Describe how injury occurred

NIA 28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one)

12 Certifying Phyelcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stetad.

29b. Signeture end title of certified

5 Pending investigation

6 Could not be detarmined

Hospital:

30. Name and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

29c. License number

1 Yas 2 No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

State Registrar

Andersm 31. Dete filed (Month, Day, Year) MAY 1 1 2000

MO 32 Registrar's Signeture

2 ER/Outpatient 3 DOA

28b. Tima of Injury

N

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Joyce Alfreda Williams MAY 08, 2000 10:45Pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Prince George Medical Center Cheverly Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. Month, Dey. April 9. Birthplace (Stete or Foreign 1937 D.C. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Months 579-54-8828 1 M 20 F 63 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Yes 2□ No D.C. Washington 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 535 Edgewood Street, N.E. 20017 U.S.A. 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 1 ☐ No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 t h College (1-4or 5+) Laundry Worker Service 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumeme) James Young Rosetta West 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stefe, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Wash. 20017 D.C. 535 Edgewood Street, #2 Eugene Thomas Step-son 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlal 2 □ Cremation 3 □ Removal from State Forest Hills Ceme. 5/13/00 Clinton, Md 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Funeral Service 21. Signature of Funeral Service License 1601 Kenilworth Avenue Washington, D.C. 20019 complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part Inter the disease, or shock, of heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Finel diseese or condition resulting in death) Due to (or as e consequence of): OT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequenca of): lmonary arrest Brown 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ₩ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

with the Maryland

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumstic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0020

attending physician end for use as the bunal-transit signed by the at Id be detached fo should is certificate has director, pege 2 this funeral

Physician/Medical

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Completed

Be

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Certification:

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Attending Physician: ŏ Illed in 24 hours

edical Within 2 To the State

31. Date filed (Month, Dey, Year)

29b. Signature and title of certifier

2 Accident

3 Sulcide

29e. Certifier

4 Homicide

(Check only

1 0 2000

investigation

6 Could not be determined



28e. Place of Injury - At home, farm, street, factory, offica bullding, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D54 35

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year)

DHMH 16 Ray 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMENDED ITEMS #8 #20b PER FH G784 6/5/2000 AH Copies Are L 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** John Paul Atkins May 2:45 PM 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8435 Arbor Station Way Baltimore Baltimore | House | Min. | 8. Dete of Birth | 1 | 26 | 55 | 9. Birthplace (State or Foreign Country) | 11 | 26 | 1035 | MARYLAND If Under 1 Year 7. Age (In yrs. last birthday) 5. Sociel Security Number 6 Sax **Funeral** Months Deys M 20 F 220-62-3893 44 Yrs. Director Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic avent, the Medical Examiner must be notified at BALTIMORE 1 ☐ Yes 2 1 No MARYLAND Director BALTIMORE 10e. Street and Number 10f. Zio Code 10g. Citizen of Whet Country? 8 8435 ARBOR STATION WAY Herrs 23s 21234 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritel Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or then page. 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry WILDLIFE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) Elementery/Secondery (0-12) College (1-4or 5+) CONTROL & PIPISTRELLU RESCUE PRESIDENT 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be KENNETH FRANKLIN PARKS, SR. ROSALIE MORGAN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. LYNN HAZELGROVE (SISTER) 1431 PHOENIX ROAD, SPARKS, MARYLAND 21252 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlel 2 X Cremetion 3 ☐ Removel from Stete TOWSON, MARYLAND 5-19-00 CORP. 4 □ Donetion 5 □ Other (Specify) HILITOP SERVICE CORP.

22. Name end Address of Fecility 21. Signature of Funerel Service Licensee RUCK TOWSON FUNERAL HOME, INC. WALLACE S. BROOKS, JR. PER DVR. 1050 YORK ROAD, TOWSON, MD 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate tritervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Neoplasia e. Multiple Endo Endocrine 1824S Examiner Examiner (ears Carcinoid physician and s the buriel-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Box 68760 Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of) for use as The law requires that the death P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records. 50 2 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 2 1 □ Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director, 25. Was case referred to medical å 26. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Netural 5 Pending investigation after death.
I Director: Aft
d in by the fur NA 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f, Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospitat or A within 24 hours after To the Funeral Direcompletely filled in b 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. Medical 29e. Certifier (Check only one) 29b. Signature end title of certified 29c. License number 29d. Date signed (Month, Day, Year) 043263 112 Lutherville, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 rathgeb MD DINO 10 31. Detertiled (Month, Dey, Year) 32. Registrer's Signeture State MAY 3 Registrar **DHMH 16 Rev 6/95**

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Physician Samuel Shelby Adams, Jr. May 26, 2000 10:27PM /Medical 4a Fscility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 15025 Falls Road Butler Baltimore 6. Sex 12 M 2 ☐ F If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 91 Vrs Director 148-01-0523 Dec. 13, 1908 Maryland Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28a-f shor 1 Yes 2 No Director MD Baltimore Butler 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "nafural", or items 23s 15025 Falls Road USA Funeral 21023 12. Wes Decedent Ever in U,S. Armed Forces? 1 2 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 11. Marital Status 1 □ Nevar Married 2 □ Married If Yes, Give Year or Dates: 43*-45* Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 N/A Grocery Merchant 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be Samuel S. Adams, Sr. Hattie Maude Adams 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If New 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Ann Adams Parks/Daughter 15025 Falls Road Butler, MD 21023 20b. Place of Disposition (Name of cometery, crematory or other place)
Baltimore, Washington 20a. Method of Disposition 20c. Location - City or Town, State May 27, 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2000 Laurel, MD Crematory 21. Signatura of Funeral Sun 22. Nama and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Inc. Michael J. Flagle 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one cause on each line. **Physician** Immediate Causa (Final disaasa or condition rasulting in deeth) /Medical 6 months UNG Examiner physician and s the burlatransit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseese or injury that initiated evants resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 Yas 2 No 1 ☐ Yes 2 No certificata Division of Vitai Attanding Physician: Be 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural 1 □ Yes 2 □ No death. e Hospital or Attandii n 24 hours after death. e Funeral Director: A bletely filled in by the fi 2□ Accidant 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 10 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and dua to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier To the Fune (Check only one) To the within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) ellem Vance MI 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Lina Y. Melhem

MAY 3 1 2000

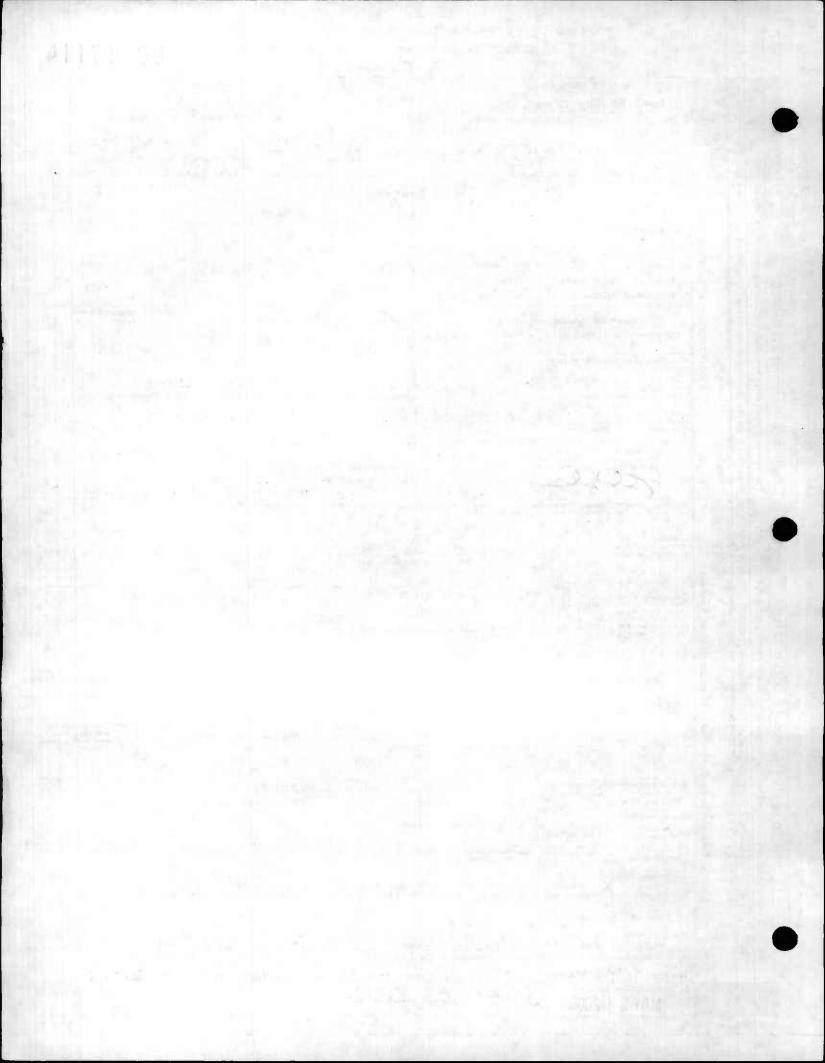
31. Dete filed (Month, Day, Year)

10755

32. Registrar's Signatura

Falls

RL # 460 Litherville MD



	1.1	DAMS	State of Maryla		te of Death	Re	g. No.	3. Time of Death	
Physician /Medical		Decedent's Name (First, Middle, Last,	K. ADA	7M5		2. Date of Death	2 ^{Day} 2000	2208	
Examiner		Facility Nema (If not institution, give 4211 WOODMERE	street and number) AVE		BALTIM	or Location of Death	ath 4c. County of Death		
Funeral Director	2	17-10-176/	7. Age (In)	Yrs. last birthday) If Und Month	er 1 Year If Under 24 H	rs. 8. Date of Birth	Year) Co	hpiece (Stete or Foreign nuntry) MD,	
death with the Maryland res 23s or 28e-f show remail be notified at	108	a. Stete 10b. County Md, NA	10c.	City, Town or Location ANNAPO	/ı's			10d. Inside City Limits	
ther death with the Ma r Items 23s or 28s-1s instrumed be modified Funeral Director	106	5. Street and Number 42/1 W00	DMERE	101. 2	2/2/5	11	Og. Citizen of What Co	untry?	
or he		Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		seedent of Hispanic Origin? (Specity Yes or No- ppecity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Specity: BlACk				
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Mental H Mental H arked out attc ever	17.	Fathar's Nama (First, Middle, Last) LEW'S F	Adams	1 3 13	18. Mother's N		HER ME		
nd 2 allth ar treu	19:	a. tnformant's Neme/Reletionship (Ty UANDA BRAFTON-WO	OTEN (daught	EA) 8528	ss (Street end Number or LUCERNE	RD, E	Alto mo	1	
00 -	208	a. Method of Disposition 1 SZBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	lemoval from State	b. Place of Disposition (A cematery, cramatory of GARRISON	FOREST	5-31-00	Balto. N	ed.	
permit. Page Department Important: if eny Injury or once.	21.	Signatura of Funaral Sarvice License		22. Nama	and Address of Facility G	rlfon C. Do	suglass Fune	ral Service	
Medical Examiner sthe bufal-transit at the bufal-transit action Examiner	Se if a ceu Ca	mediate Cause (Final asase or condition sulting in death) quentially list conditions, any, leeding to immediate use. Enter Undarlying use (Disease or Injury to Indiated events sulting in death) Last	Due to	o (or as a consequence of o	i):	e			
auth certificate attending physical for use as the clan/Medic			1.						
by the tached	Par	t II. Other significant conditions con	stributing to death but not	resulting in the underlying	cause given in Pert I.	23b. Did to	./	to the causs of death robably 4 Unknow	
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The law requirate has been single 2 should	25.	Was case refarred to medicel examiner? VIM Yas 2 □ No	fospital:	□ EB/Outpatient 3□	Other	Death (Check only on		cifu)	
fing Physicien: The law required. In. In. In. In. In. In. In. I	25.	examiner? X X Yas 2 No Manner of Death 1 Dinatural 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Day Year	М	OOA Other: 4 Nursing 28c. trijury at Work?	g Home 5 Reside	once KXOther (Spe ow Injury occurred	JULINE	
fing Physicien: The law required. In. In. In. In. In. In. In. I	25.	examiner? X X Yas 2 No Manner of Death 1 Naturai 5 Pending 2 Aocident 3 Suicide 6 Could not be determined	28a. Dete of Injury (Month, Day Year) 28e. Place of Injury - A building, etc. (Spe	28b. Time of Injury M at home, ferm, street, fectocify)	OOA Other: 4 Nursing 28c. tnjury at Work? 1 Yes 2 No ony, office	g Home 5 Reside 28d. Describe ho 28f. Location (St City or Town	nce KMOther (Spe by Injury occurred reet and Number or Ro , State)	urel Route Number,	
Hospital or Attending Physicien: The law requir & hours after death. Eureral Director. After this certificate has been s tery filled in by the funeral director, page 2 should ilical Certification: To Be Completed	25.	examiner? X X Yas 2 No Magner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide a. Certifier 1 Certifying Physical Research Processing Investigation 6 Could not be determined	28a. Dete of Injury (Month, Day Year 28e. Place of Injury - A building, etc. (Spe	28b. Time of Injury M at home, ferm, street, fect ecity) knowledge, death occurre	OOA Other: 4 Nursing 28c. trijury at Work?	g Home 5 Reside 28d, Describe ho 28f, Location (St City or Town	w Injury occurred reet and Number or R. , Siate) suse(s) and manner as	urel Route Number,	
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Registrar

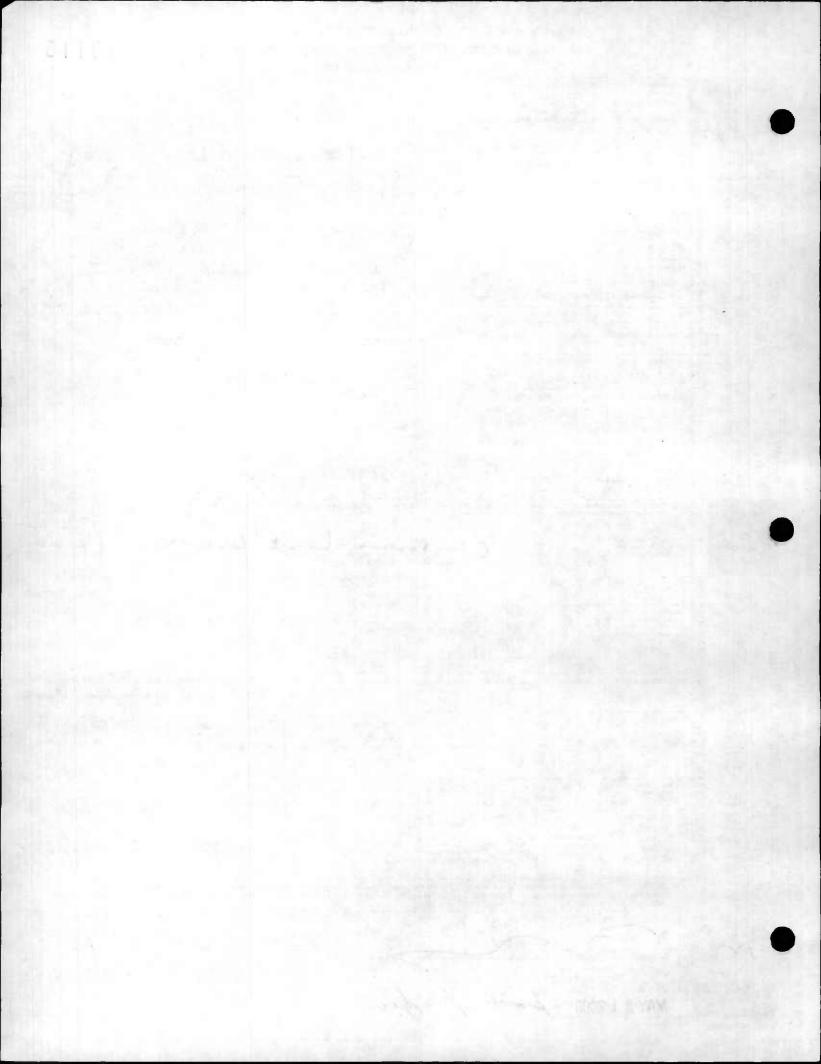
DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0

				Ce	ertificate	e of	Death			Reg. No.				
	Dhoristan	1. Decedent'a Nama (First, Middla, L	ast)						2. Dete of De		Yaar	3. Tima of Death		
3	Physician /Medical	CATHERINE L. AHMI	JTY						MAY 28	3, 2000	1 (441	6:00 A.M.		
	Examiner	4a Facility Name (If not institution, gr	va street and number)				4b. City, To	wn, or L	ocation of Deal	th 4c. Count	y of Death			
		116 MAPLE AVE.					PASAD			ANNE	ARUND	EL		
	Funeral Director	220-30-2037	Sex 7. Aga (In)	yrs. last birthday Yrs.	Months	Days		24 Hrs. Min.	8. Data of Bi	nth Year) 1928	9. Birth	place (State or Foreign ntov) YLAND		
pue	1	Usuat Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation						1.	10d. Insida City Limits		
th the Maryland	be notified at Director	MARYLAND ANNE ARI		SADENA					1 □ Yes 2 No					
ath with		10e. Street and Number 116 MAPLE AVE.				122				ntry? ES				
5-0020 72 hours after de	Examiner must Examiner must by Funeral	11. Marital Status 1 Navar Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedant Evar i Armed Forces? 1 ☐ Yas 2 ☑ No if Yas, Giva Yaar or Datas:	n U,S. 13.	Was Decede If Yas, speci 1 ☐ Yas 2				pecify Yas or No Pican, etc.)	o- 14. Ra Ble Speci	ick, Whita,	can Indian, atc. IITE		
21215-0020 d within 72 hours al	ygiene. wer than "mahun rt, the Medical. Completed	15. Decedent's E (Specify only highast gr	ducation ada completed) College (1-4or 5+)	(Give	16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifta. DO NOT use retired) HOMEMAKER OWN HOME							dustry		
D a	d other event, Be C	17. Father's Nama (First, Middla, Las)				18. Moths	ar's Nam	a (First, Middle	, Ma <i>id</i> an Suma	ma)			
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Maryland	N Dun	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Addrass	(Stree	t and Numb	er or Au	IZEL ural Routa Number, City or Town, Stata, Zip Coda)					
- 8	12.5	ROBERT AHMUTY, SI	R. / HUSBAND	116	MAPLE	AV	E., P.	ASAD	ENA, MA	RYLAND	21122			
Baltimore	nt: if lien ny or oth	20e. Method of Disposition 1 Burial 2 Cremetion 3 [4 Department 5 Other (Special Content of the Content of th	Ramoval from Stata	b. Place of Disp cematary, cra LEN HAV	matory or off	har pla			MAY 31					
Balt	Departm Imports any inju	22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061												
		23a. Part1. Entar tha diseasa, or con shock, or heart failure. List only	oplications that caused the d								,	Approximeta		
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EX	aminer	resulting in death)	aDua t	o (or as a conse	quence of):			- 3	1					
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stron	n and lateranelt Examine	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying	Dua t	o (or as a conse	quence of):									
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x 68760,	s the bu	Cause (Disease or injury c. ———————————————————————————————————												
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Division of Vital Records, to Attending Physician: The law requires t	cate has been signe , page 2 should be d Completed by									s an autopsy omed?	av	Tara autopsy findings rallable prior to ompletion of cause death?		
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Division the Hospital or Attending	within 24 hours after To the Funeral Discompletely filled in Medical Cert	29a. Cartifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of my miner: On the basis of axam and mannar stated.	knowledge, deal ination and/or in	th occurred an	t the ti	ime, data an opinion, des	d place, th occur	and due to the red at the time	cause(s) and m	anner as s , and due t	stated. o tha cause(s)		
To	Total Z	29b. Signatura and titla of certifier	THE RESERVE		29c.	Licen	sa number			29d. Dete sign	ed (Month,	Day, Year)		
	00	K.			D	18	508			MAY 31,	2000			
((Y)	30. Name end address of person who CHARLES J. WU, M.				E 1	06. GI	LEN	BURNIE.	MARYI.A	ND 21	061		
	State Registrar	31. Data filed (Month, Day, Year) MAY 3 1 2000	Several 32. Registrer's Si	gnatura /	als		, ,		,					

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** 30 2000 May Verna Denise Beck 6:00PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Harbour Inn Convalescent Center Baltimore H Under 24 Hrs. 8. Data of Birth (Monit, Day) (Year) 1933 If Under 1 Year 5. Social Security Number 6. Sex 9. Birthplace (Stata or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Months Days Yrs. 66 Director 220-30-5428 Usual Residence of Decedant 10a Stete 10c. City, Town or Location 10h County 10d. Inside City Limits 1 Yes 2 No Director n/a Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 238 United States 21229 3619 Greenvale Road Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: Department of Health and Dahertal Hygiene.
Important if Item 27 is merked other the any Injury or other trausments. 14. Race - American Indian, Black, White, etc. or itsms Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Collections Agent 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Adelaide Sparrow Vernon Benner 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Intormant's Name/Reletionship (Type, Print) 3619 Greenvale Road Baltimore, MD 21229 Iva Leona Rausch (Sister) 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 16/3/00 Baltimore, MD Loudon Park Cemetery 21. Signatura of Funaral Sarvice Lider 22. Name and Addrass of Fecility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that bius shock, or heart tailure. List only one and each not entar tha mode of dying, such as cardiac or raspiratory arrest, Approximata Interval Between Onset and Deeth **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical ONCRANTER **Examiner** Due to (or as a consequence of): Physician/Medical Examiner 5 su attending physician and for use as the burial-transit law requires that the death certificate be assecuted Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Ceuse (Disaasa or injury for es a consequence of) Box 68760. that initiated avants rasulting in death) Last Dua to (or as a consequence of): P.O. signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? certificate 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case rafarred to medical axaminar? Be 26. Place of Death (Check only ona) 30 No Other: Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Natural 2 Accident 5 Pending invastigation Uneral Director: After the further of the filled in by the further 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Discompletely filled in edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian (Check only one) 29b. Signature and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) 014571 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) lto, md. 21202 C. THOMAS FOLKENER It Paul Jta 517 31. Data tilad (Month, Day, Year) 32 Registrar's Signatura State MAY 3 1 2000

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Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 29, Irene Brigid Burns 2000 3:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Canton Harbor Nursing Home Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sax 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 255 219-07-5771 Yrs. 78 Director Aug. 5, 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Directo N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 230 21224 United States 1101 South Ellwood Ave. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Maryland 21215-0020 natural, or 1 Yes 2₺ No Specify: Specify: White 3☑ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Years permit. Papes 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked ofth any fillury or other traumatic event about 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Marie Kowalewski Michael William Szczesniak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. Box 702 Bunker Hill, West Virginia 25413 Rita D. Gower (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State H Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 6/1/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in List only one cause on each line. 23a. Part1. Enter the dis shock, or head tell Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed ician and burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Records. 2 Lely destin 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? i certificate has t 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vitai 25. Was case referred to medical examiner? Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 0 4 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 (Dinatural 5 Pending s after de-al Director: Aftr 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral Dire letely filled in b 5 Hospital Medical 1 Continuing Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signetyre and title of certifier 111001191 008358 BACTICADEE RATEGIAND 21224. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 703 GPA Ch V. PATRICO REC

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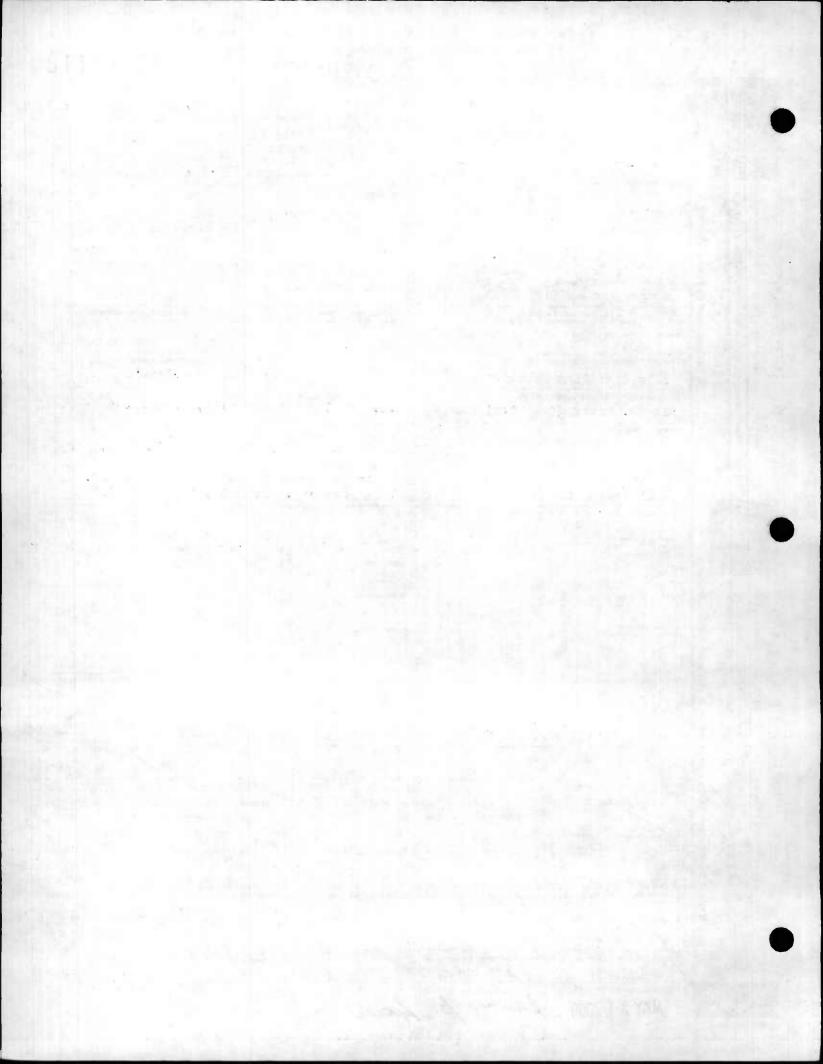
State

Registrar

31. Date filed (Month, Day, Year)

MAY 3 1 2000

32. Registrar's Signature



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Deeth 9:00 PM Month Day **Physician** 25-IRENE L. BOYER 05 -00 /Medical 4c. County of Deeth 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner (HOME WOOD FUTURE CARE BALTIMORE If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 10 M 20 F Hours Days Months 88 Yrs. 216-12-2202 05-18-12 NO Director Usual Rasidence of Decedant 10d. Inside City Limits 10a, Stata 10b. County 10c. City, Town or Location 1 Yes 2 No NIA Directo MD BALTIMORE 288-1 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 23a or 103 WICKLOW ROAD 21229 USA Funeral Was Dacedant Evar in U.S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11. Merital Stetus Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yaa, Giva Yaar or Datas: 1 Never Merried 2 Married ö altimore, Maryland 21215-0020 1 Yas 2 No Specify. Specify: BLACK þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) DOMESTIC 9 TH GRADE HOME NA 17. Fether's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Department of Health and Mental Important: If Nem 27 is marked or any Injury or other traumatic even ALBERT LITTLE MINNIE 19a. Informant'a Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 2101 HOLDER AVE., BALTO. MD. 21207 SON FREDERICK SIMMONS 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stete 106-01-00 BALTIMORE, MO 4 ☐ Donation 5 ☐ Othar (Specify) ARBUTUS MEMORIAL PARK 22. Nama and Addrass of Facility 21. Signeture of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE BAUTO. MO. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or man failure. List only one cause on each line. Approximata Interval Batween Onsat and Deeth **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last bunial-tran and Due to (or es e consequance of): Box 68760 physician Physician/Medical the Dua to (or as a consequence of): for use as P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? be detached 1 Yes 2 No 3 3 Probably 4 Unknown Completed by of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should this certificate has 1 ☐ Yas 2 ☐ No after death. Director: After this certification of the funeral director, Physician: 25. Was casa rafarrad to medicel axaminar? Be 26. Placa of Daath (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Deeth 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 2 Accidant Division or Attending 5 Panding invastigation 1 Yas 2 No 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28e. Pleca of Injury - At home, farm, streat, fectory, office building, etc. (Specify) filled in by 4 Homicida To the Hospital or To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifier completely (Check only one)

State

DHMH 16 Rev 6/95

Registrar

MAY 31 2000

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30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print)

TEY my 301 ST-32. Registrar's Signatura

Jus

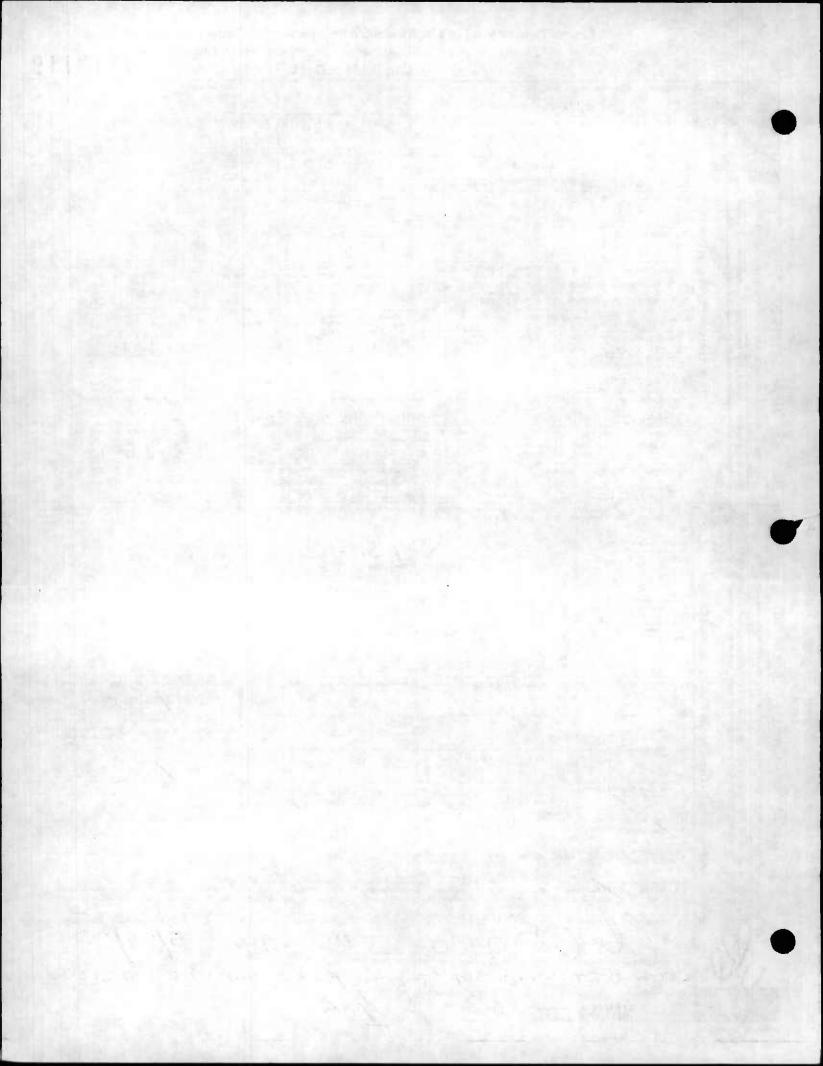
PLACE SUITETIS MD ZIZOZ

29c. Licansa number

29d. Data signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

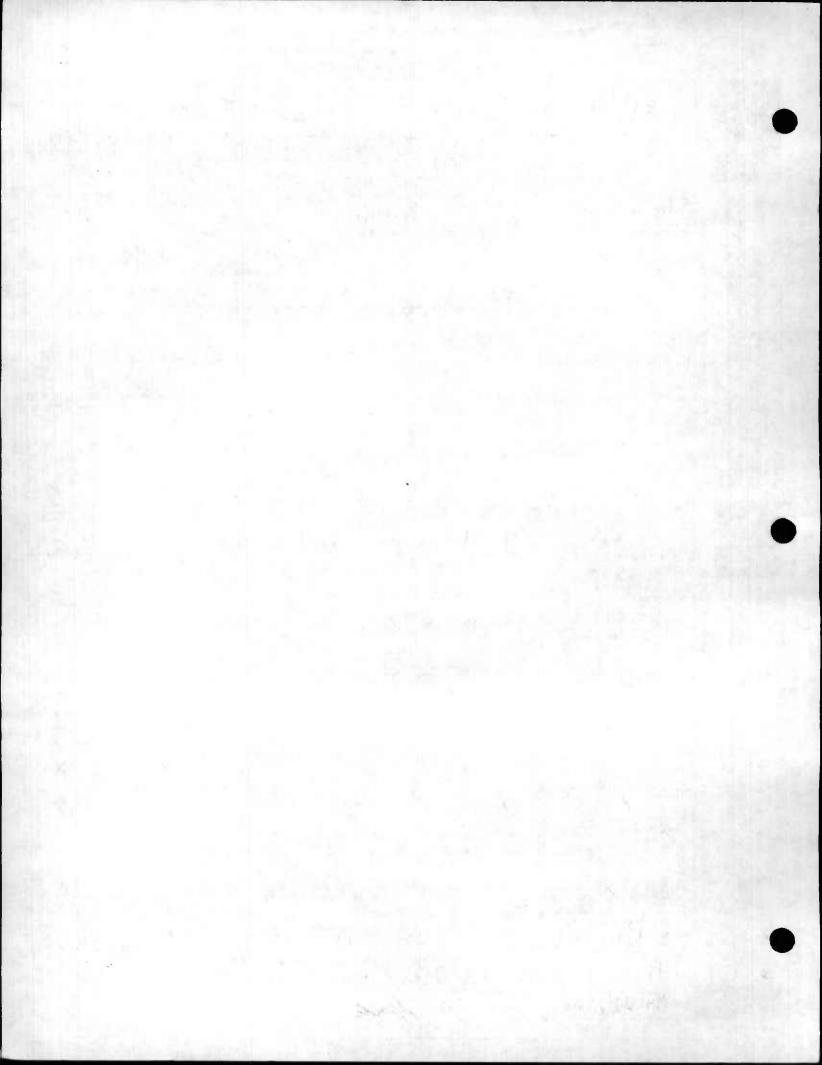
29b. Signatury and the of certifie



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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= 8		te. Method of Disposition 1 □XBuriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	Removet from State Ced	emetery, cremetory or lar Hill Ce	other piece) metery 5	/30/2000		The second second
important any injury 2008.	21	1. Signature of Funeral Service Licen	Mine	McCul	ly-Polyniak Fort ave.,			
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DHMH 16 Rev 6/95



within 24 hours efter deat To the Funeral Director: the Hospitai completely

State Registrar

Medical

(Check only

29b. Signeture and title of certifier

31. Date filed (Month, Day, Year) MAY 31

PANI

MO, NHC 32. Registrar's Signature

30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print)

BACTO.

29c. License number

MO 21133

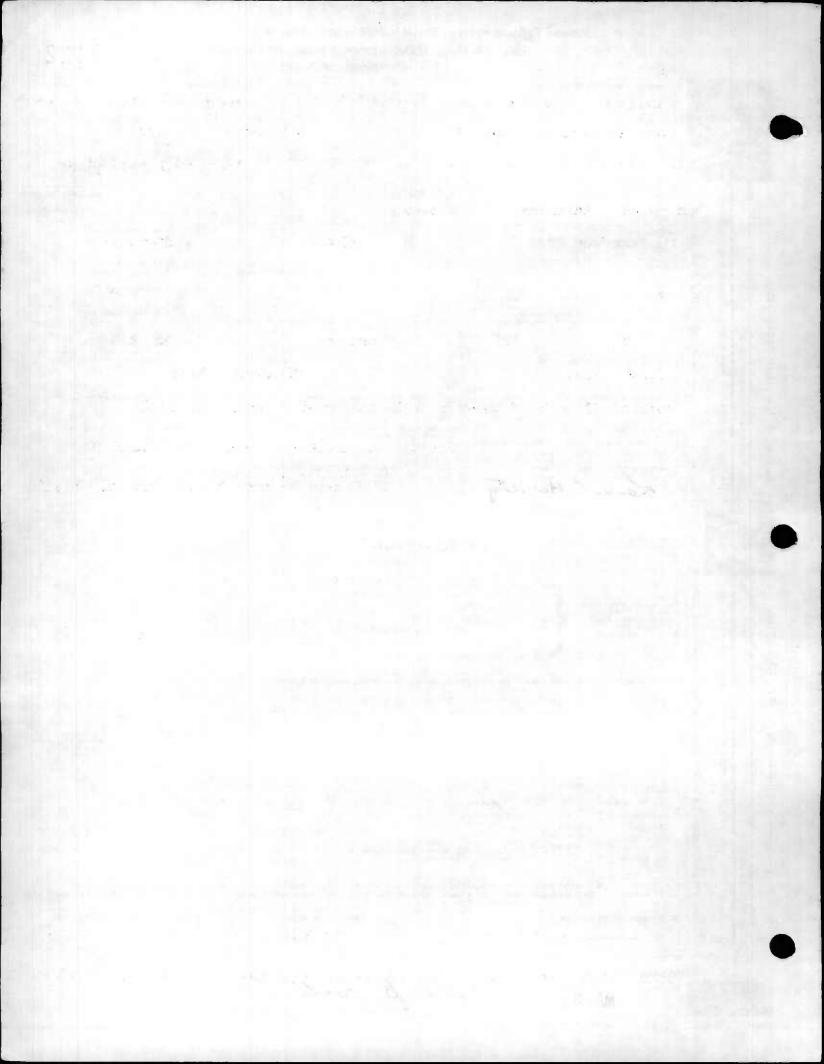
29d. Date signed (Month, Day, Year) MAY 29, 2000

DHMH 16 Bey 6/95

Please Type or Print In Black Indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 17122

			Certifi	cate of	Death		Reg. No.	1 /	166	
Physician	1. Decedent's Name (First, Middle, Last		BATTL	10 5		2. Date of De Month	. Day	Year	3. Time of Deeth	
/Medical Examiner	LILLIAN V 4a Facility Name (If not Institution, give Good Samaritan		SATT	7 2	4b. City, Town, or Baltin			of Death	3:37-P1	
uneral	5. Social Security Number 6. Se			Under 1 Year	If Under 24 Hrs		rth y 7,1914	9. Birthpla Country	ace (Stete or Foreign	
rirector	Usual Residence of Decedent					Sandar	y /,±/±7	Mary	Taliu	
is marked other than "natural", or items 23s or 28s-f show raumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Maryland Baltime		ity, Town or Locatio	ń				10	d. Inside City Limits	
al Direct	10e. Street and Number 111 West Road		11	21204			10g. Chizen of V United			
Examination must be notified by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 図 No If Yes, Give Year or Dates:	1	Decedent of s, specify Cub res 2 No	Hispanic Orlgin? (Span, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)		e - America ck, White, e :: White	tc.	
eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's	Usuel Occu of work done	pation during most of wo	rking	16b. Kind of B	usiness/Indi	ustry	
ompl	Elementary/Secondary (0-12)	College (1-4or 5+)		IOT use retire ISEWife			Own H	ome		
atic event, the Medical I	17. Father's Name (First, Middle, Last) Jacob Young					Name (First, Middle, Melden Sumeme) Limina Ruehm				
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumetic event, the Medical Examiner must be notified as once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (7) Beverly Lillian Be	rpo, Print) elt/ Daughter	19b. Mailing Ad 4 Winga	idress (Stree te Gar	t and Number or R. th Timo	ural Route Numb nium, MI	per, City or Town, 21093	Stete, Zip (Code)	
int: if item iry or othe	20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from Stete	Plece of Disposition cometery, cremeto udon Parl	y or other ple	tery	Date 6/1/00	20c. Location - Baltimo			
Importa any inju	21. Signature of Funeral Service Licens		² CA1 871	A Ster	phén D. I en Pastur	ohrmann es Driv	P.A. e Baltim	ore,	MD 21286	
the attending physician end indeed for use as the burial-transit indeed for use as the burial-transit indeed for its angle in the state of the state	disease or condition resulting In deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last									
d for u	Part II. Other significant conditions cor	stributing to death but not ro	culting In the under	ulna cauco ci	hon in Part I	23h Did	tohecco use co	ntelbute to	the cause of death?	
detache	Tach. Other significant conditions con	minuting to death but not re	Surfing III (ne dilden	ying cause g	von in Fait i.		Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknow			
cate has been signed by the attend ; page 2 should be detached for us Completed by Physician/			14			24e. Wes	s an autopsy ormed?	ava	re autopsy findings ilable prior to apletion of cause eath?	
page 2						10	Yes 2. No	10	Yes 2□ No	
rector, pag	25. Was case referred to medical examiner?	fospitel:				ath (Check only	one)			
1 E	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	-	T	Idence 8 Oth)	
pleasy filled in by the funeral calical Certification:	3 Sulcide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, street, f ify)	actory, office		28f. Location City or To	(Street and Numb wn, State)	er or Rural	Route Number,	
funeral Direction by Series Certification Ce	29a. Certifier (Check only one) 1 Certifying Physical Example 2 Medical Example 1	sician: To the best of my known or the basis of examinand menner stated.	owledge, death occ ation end/or Investig	urred et the t petion, In my	lme, dete and place opinion, death occ	e, and due to the urred at the time,	cause(a) and ma date and placa,	anner as sta and due to	ated. the cause(s)	
Me	29b. Signature and title of certifier	,		29c. Licen			29d. Date signe	d (Month, D	Day, Year)	
		one !		191	1390		May	30,	८०००	
1/	30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type, Print)						
	MONA SABRA, MM	5601 W	CH RAVE	. 1 D.	10 0	ALTIM	705 11	10 2	1239.	

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Day Year BROWN MAY 23 2000 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL CENTER BALTIMORE If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 1□M 2XF Yrs.

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** CLAUDETTE 4.55 pm /Medical 4a Facility Name (If not institution, give street and number) Examiner HARBOR 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director 217-80-7681 M.D Usual Residence of Decedent 10b. County 10a Stata 10c. City, Town or Location 10d. Insida City Limits ahow ir than "natural", or hams 23a or 28a-f ahov The Medical Examiner must be notified at 1X Yes 2 No Directo MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4412 Parkton Street 21229 U.S.A. Funeral death 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces?

1 Yas 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 end 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 la marked other than "natural", or ther any Injury or other traumatic event. the 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elementary/Secondary (0-12) College (1-4or 5+) Cashier llth grade Value City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Priscilla Tate Edward Walace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 Priscilla Brown-Mother 4412 Parkton Street, Baltimore Md 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 5-30-00 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licens 21215 4300 Wabash Ave, Baltimore Md 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final PISSEMINATED INTRAVASCULAR COAGULATION disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner METASTATIC 3 MONTHS CANCER BREAST physicien and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? has 1 Yes 2 DNo 1 Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes P No Inpatient 2 ER/Outpatlent 3 DOA 10 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? al or Atta...
urs after death.
eral Director: Afte 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral Discompletely filled in † Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certified P 11949 RESIDENT PHYSICIAN 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center, 3001 S. HANOVER ST., BALTIMORE, MD-21225 Moghekar . Houser Mospilal

State Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Day, (ear) 2000

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2 Date of Death 3. Tima of Death MAY 25 Pay 200° MYRTLE LOUISE BAYNE 8:25 p.m. 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth Month, Den Year JULY 27, 1904 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplaca (Steta or Foreign Days 1□M 2♥F 214-01-7323 95 MARYLAND Yrs. Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No BALTIMORE RIDGELEIGH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8320 OAKLEIGH ROAD 21234 IISA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11, Marital Status 14. Race - Amarican Indian. Bleck, Whita, atc. 1 ☐ Yes 2 No If Yes, Giva Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 V Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5th GRADE SEAMSTRESS DRESS FACTORY 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) SAMUEL HOLMES MARY MAULE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) MYRTLE LORRAINE TITTLE/DAUGHTER 9114 SIMMS AVENUE BALTIMORE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata ↑☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation /5 ☐ Other (Specify) GARDENS OF FAITH CEMETERY 5/30/00 PARKVILLE, MD 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licenses JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. BALTIMORE, MD 21286 lea 100 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one dause on mach inner. Approximata Intarval Batween Onsat and Daath Immediate Cause (Finel disease or condition resulting in death) a CANCER OF UNKNOWN PRIMARY Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ₺ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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MD

Funeral

Director

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72 hours after

filed within

permit. Pages 1 and 2 ahouid be file Department of Health and Martal Hy Important: If Nem 27 is marked other any Injury or other traumatic avens

Maryland

P.O. Box 68760,

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of Vitai

Division

Myrtle Bayne

2000

Examiner Physiclan/Medical à

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25. Was case referred to medical axaminer?

1 Yes 2 No

29a. Certifier

(Check only one)

Medicai

State

Registrar

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be 3 Suicide 4 Homicide

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

Other: 4 Nursing Homa 5 Residence 6 X Other (Specify) HOSPICE 28c. Injury at Work? 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the

28d. Describe how injury occurred

24a. Was an autopsy performed?

26. Place of Deeth (Check only one)

1 Yas 2 No

29b. Signature and little of castiline n 29c. License number D43725

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date end place, end due to the ceuse(s) and manner stated.

29d. Data signed (Month, Day, Year) 26(00

24b. Ware autopsy findings available prior to completion of causa of death?

1 □ Yas 2 □ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

MAY 31

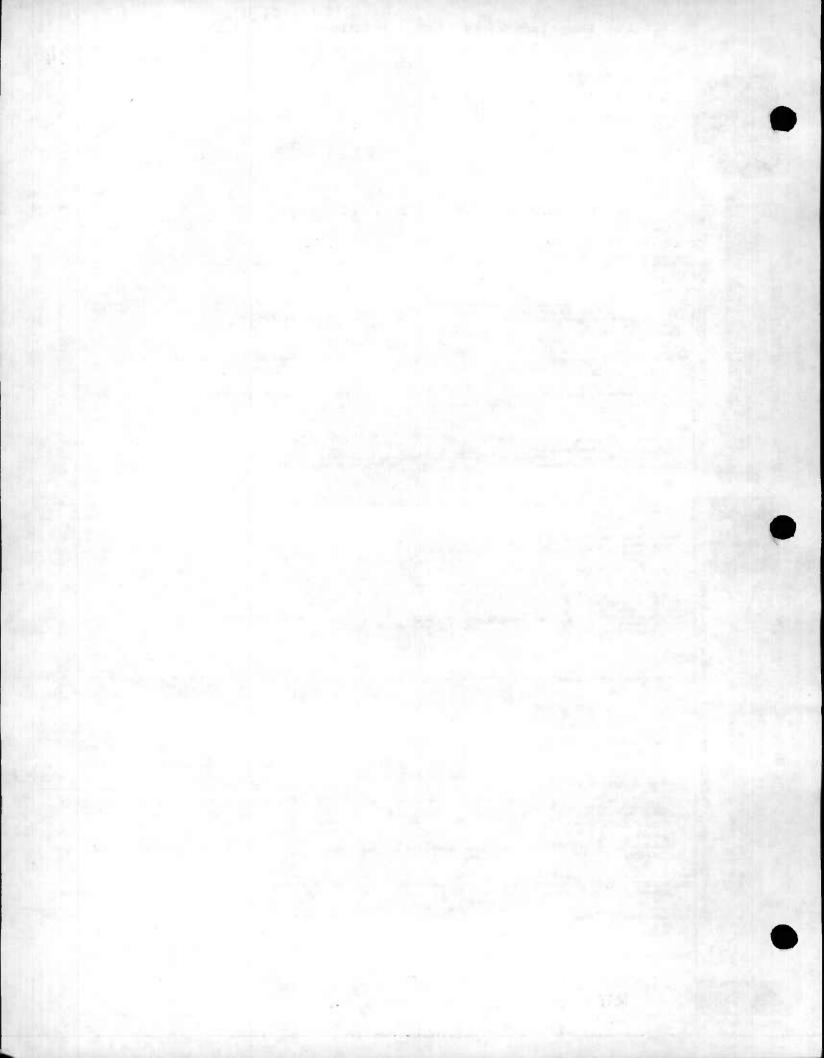
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TIMONIUM, MD 21093

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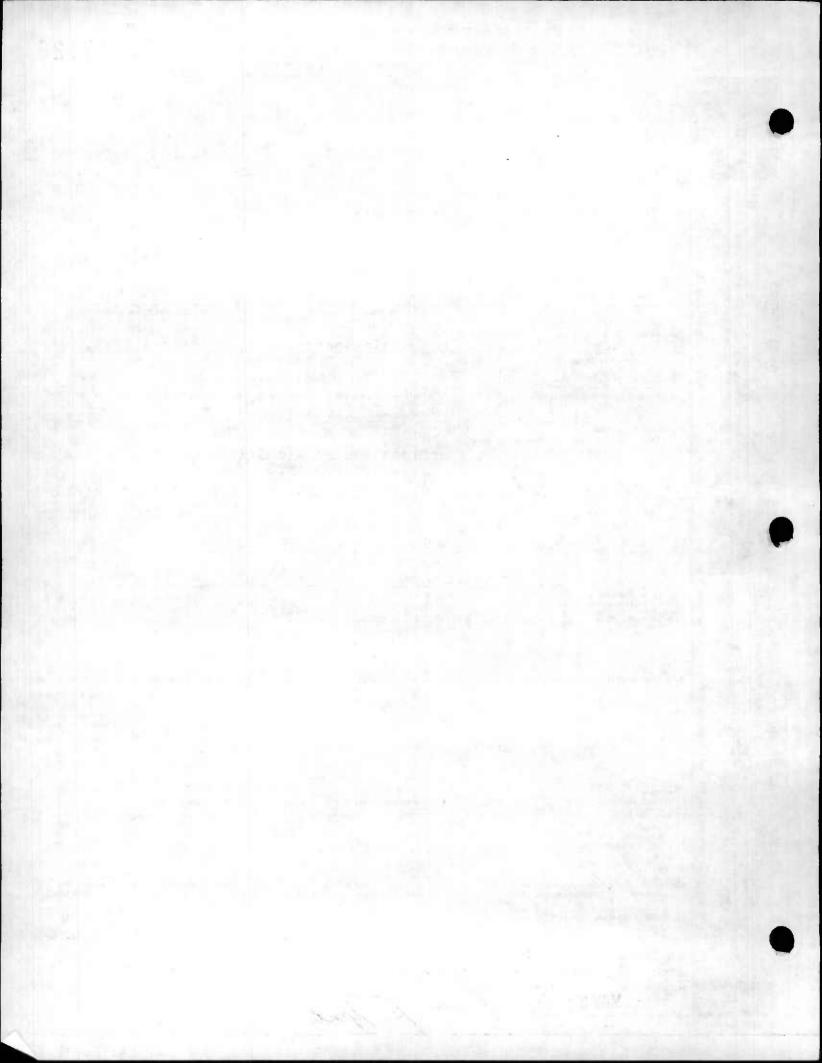
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/Medical	R	100		BOI	VD			0. 7.	Month	28	2000	2:20 AN
Examiner		Name (If not Institution SAMA	n, give street AR) TA		SPITAL				MORE		nty of Death	
uneral rector		-62-6636	6. Sex		yrs. last birthday, Yrs.	Months		Hours M	in. (Month, L	irth Pay, Year)		place (State or Foreign
ž	Usuat Res	idence of Decedent		10c	City, Town or L	ocation						Od. Inside City Limits
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be notified Director	10e. Stree	t and Number				10f. Zip C	ode			10g. Citizen o	of What Coul	ntry?
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To E	2 James Bond Jr. Delores Burse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or T											
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important: If any injury or 2008.		31/	2	9	11	2. Name and arch						
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- w	that initiat	ed events in death) Lest	d	Due to (or as a consequence of):								
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Physician/M	Part II. Oth	er significant condition URRHOS								d tobacco uas ☐ Yes 2.2 N		o the causs of death? bably 4 ☐ Unknow
d by									24a. Wa	s an autopsy formed?	24b. W	ere autopsy findings
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DHMH 16 Rev 6/95

ORIGINAL



Carroll County General Hospital Westminster If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year)
Aug. 10, 1922 If Under 1 Year 7. Aga (In yrs. last birthday) **Funeral** 77 **Director** 216-16-5340 Usual Rasidenca of Dacedant 72 hours after death with the Marylend 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinas must be notified at Maryland Carroll Hampstead Director BARNES. WARREN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1326 Main Street Apt 12 21074 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Yes 2 □ No if Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2€ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Levi Barnes Bessie Todd To 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 0 19a. Informant's Name/Relationship (Type, Print) 4401 Roland Avenue #405 William Barnes Cousin 20b. Place of Disposition (Nama of camatery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Providence Cemetery 5/30 Other (Specify) Gamber, Maryland 4 Donation Funeral Sarvice Licenses 22. Name end Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, MD additions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, in failura. List only ona causa on each lina. 23a. Part1. Entry shock, or h **Physician** /Medical Immediate Cause (Final Wid Intarction disease or condition resulting in death) **Examiner** Examiner Coronary SEVUX ettending physician and for use as the buriaf-transit The law requires that the death certificate be executed

Barnes

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Wara autopsy findings available prior to completion of causa of daath?

21211

3. Time of Death

2338

9. Birthplace (State or Foraign Country) Maryland

10d. Inside City Limits

1 Yes 2 □ No

20 No 1 🗆 Yas

26. Place of Death (Check only ona)

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical 1 Yes 2 No

1 Natural

2 Accident

4 Homlcide

3 Suicide

Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in daath) Last

Physician/Medical

é

Completed

Be

Certification: To

Medical

signed by the e

been sig

s cartificata has t director, page 2 s

this funeral

After

director.

in by

Hospital or Attending Physicien:

deeth.

after deet Director:

24 hours

To the Vithin 2 To the I complet

10

27. Manne of Death

1. Decedent's Name (First, Middle, Last)

Warren

F.

4a Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Tima of

28c. Injury at Work? 1 Yes 2 No

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death

2. Date of Death

Month

4b. City, Town, or Location of Death

Day

25, 2000 th | 4c. County of Death

USA

Specify:

Plumbing

Baltimore,

14. Raca - American Indian, Black, Whita, atc.

White

Year

Carroll

28d. Describe how injury occurred

29a. Certifier 1 🗹 Cartifying Physician: To tha bast of my knowledge, daath occurred at the time, date and placa, and dua to tha causa(s) and mannar as stated (Check only one) 2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

6 Could not be daterminad

Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☑ DOA

Due to (or as a consequence of):

Due to (or as a consequenca of)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifian

29c. Licanse number D 36796 29d. Date signed (Month, Day, Year)

5.26.00

CHMMINGS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARROLL

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year) MAY 3 1 2000

COUNTY 32. Registrar's Signature

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

, the state of the s Mayor By Howard The Committee Section 12

Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Brown May 28 Day **Physician** 9:20 PM Vanie 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Truore Rehabilatation and Exteded Care Baltimore | Hunder 1 Year | Hunder 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Min. | May 7, 1921 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 410-24-3098 XXM 20 F 79 Director Kentucky Usual Rasidanca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Maryland N/A Baltimore or 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizan of What Country? 238 Funeral 4427 Newport Avenue 21211

13. Was Decedent of Hispanic Origin? (Specify Yas or NoIf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 12. Was Decedant Evar in U.S. Armed Forcas? 1√D Yas 2 □ No Ir¥as, Giva Yaar or Datas:WWII Black, Whita, atc. filed within 72 hours after 1 ☐ Nevar Married 2 ☐ Married ò Maryland 21215-0020 1□ Yes 2€ No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completad) Elemantary/Secondary (0-12) College (1-4or 5+) Machinist Steel Manufacture 17. Father's Nama (First, Middla, Last) permit. Pages 1 and 2 should be fiss.
Department of Heath and Mental Hy, Important: If Nem 27 is marked other any figury or other traumatic aware. 18. Mother's Nama (First, Middla, Maiden Surnama) Thomas Brown Hettie Pace 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 4427 Newport Avenue Martiande 21211 Anna P. Brown Baltimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Gramation 3 Ramoval from Stata 4 Donation 75 Other (Specify) 5/31/00 Laurel, Maryland Balto-Washington 21. Signature of Funaral Sarvice License 22. Nama and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, Party List only one cause on each line. tntarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical Sclevosis 20 years Examiner Dua to (or as a consequence of) Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 INO 3 Probably 4 Unknown Division of Vital Records, ρ 24b. Wara autopsy findings availabla prior to complation of cause of death? Be Completed 24a. Was an autopsy performed? 2016 certificate 1 Tes 1 ☐ Yas 2 ☐ No funeral director, 25. Wes case raferred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yas 2 No this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Natural 5 Pending deeth. 1 Yas 2 No ne Hospital or Attendii n 24 hours after deeth. ne Funeral Director: A pletely filled in by the fo invastigation 2 Accident 6 Could not be datarmined 3 Sulcida 28a. Placa of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Cartifiar 1년 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. completely (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F within 2 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifiar DO032548 10 North Greene Baltimore, M 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) COLVIN 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar 31 2000

ORIGINAL

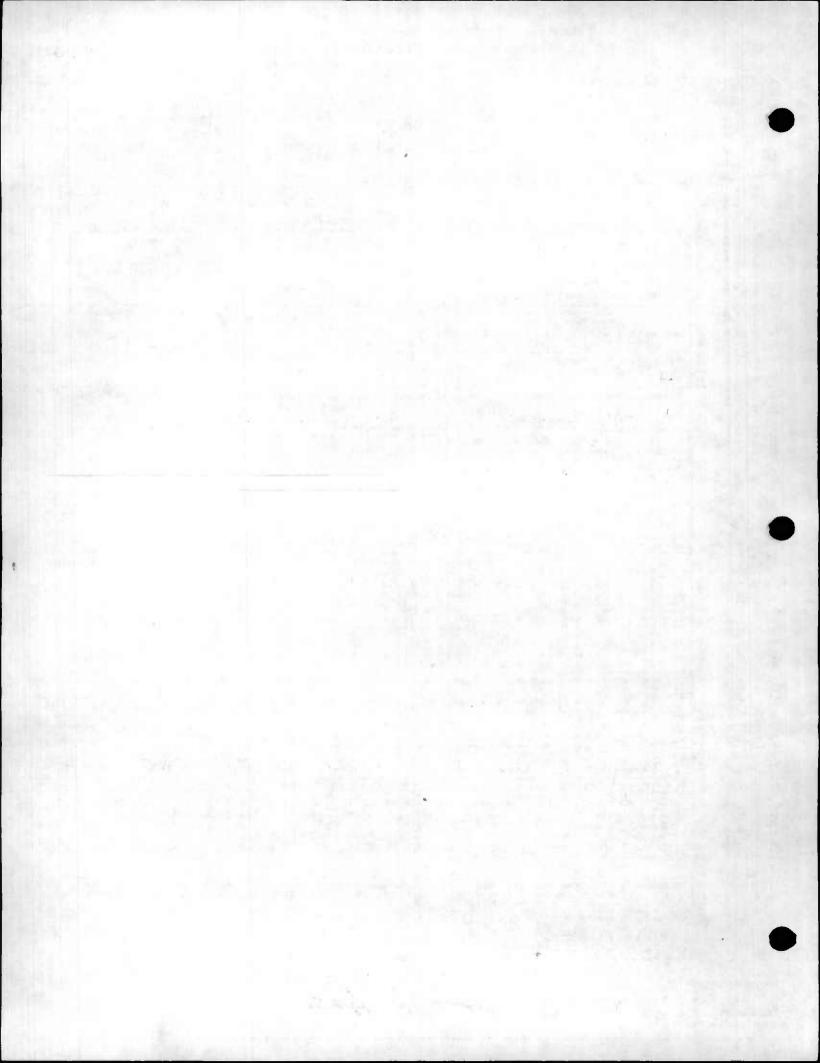
DHMH 16 Rev 6/95

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Physician	1. Decedent's Name (First, Middle, Las		Brad		2. Date of Death Month	Day Year	3. Time of Death		
/Medical Examiner	Terrie 4a Facility Name (If not Institution, give	street end number)	BLad		Location of Death	4c. County of Deal			
- LAGITITICI	1101 WILMOT CO	URT		BALTI	MORE				
Funeral	5. Social Security Number 6. S	7. Age (In y	rs. lest birthdey) If Under 1 Ye Yrs. Months Day			Year) 9. Bir	Implace (State or Foreign ountry)		
Director	217-90-6305 Usual Residence of Decedent	35			08 1	1 64	M.D.		
show ed at	10a. Stata 10b. County		City, Town or Location				10d. Inside City Limits		
officer death with the Manyland reference 234 or 284-1 show refer must be putitized at Funeral Director	Md na	В	altimore				1 No Yes 2 No		
with the Direction of t	10e. Street and Number	250000000000000000000000000000000000000	10f. Zip Cod		10	g. Citizen of What Co U . S .			
ne 23a	1101 Wilmot Co	12. Was Decedent Ever in		1202 of Hispenic Origin? (5	Specify Yes or No-	14. Race - Ame			
aryland 21215-0020 should be filed within 72 hours after and Mental Hygiena. marked other than "natural", or its umarks svent, the Medical Examina To Be Completed by Fur	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Detes:	If Yes, specify C	uban, Mexican, Pue	rlo Rican, etc.)	Black, White	ack		
	15. Decedent's Ed (Specify only highest gre		16a. Decedent's Usual Oc (Giva kind of work do	ne during most of wo	orking 1	6b. Kind of Business			
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	9th grade 17. Father's Name (First, Middle, Last)	na	File Cl		ame (First, Middle, M	leiden Sumeme)			
	Wilson Bradley	7		Vernet	thia Bro	wn	'n		
	19a. Informant's Name/Ralationship (7		19b. Malling Addrass (Str.	eet end Number or R	Rural Routa Number,	City or Town, Stete,	Zip Code)		
os 1 and 2 of Health a litem 27 is	Vernethia Rouse		3437 Edmon		1		21229		
0 00	20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removal from Stata	b. Place of Disposition (Name of cemetery, cremetory or other, cing Memorial	olece)		oc. Location - City or Randalls	town, State		
Baltimoperati. Pag Department important: i any injury o once.	21. Signature of Funeral Service Ucontect 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md								
	Part Enter the disease, or comp shock, or heart tailure. List only	ofications that caused the d					21215 Approximate Intervel Between		
Physician /Medical Examiner	Immediate Cause (Final diseasa or condition resulting in daath)	8.	OXICATION AND COCA	INE USE			Onset and Death		
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Gesth death death death	Part II. Other eignificant conditions or	ontributing to death but not	resulting in the underlying cause	given in Part I.	23b. Did tot	pacco use contribute	to the cause of death?		
Is, P.O. Box as that the deeth cer igned by the estendin be datached for use by Physician/N	PNELMONIA						Probably 412 Unknown		
Cord					24a. Was an perform		Ware autopsy findings available prior to completion of cause of death?		
I Re lav	Market Market				1 Ye	s 2 No	1 Yes 2 No		
	25. Wes case referred to medical examiner?				aath (Check only one)			
0 5 5 5	1⊠ Yes 2□ No		ERVOUIDATION 3LI DOA			nce 6 QOther (Spe	ecity) SCENE		
slon o ending Ph leath. tor: After th tha funeral	27. Mannar of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Dey Year FOUND:	TOTIKITA	njuryat Work? I□ Yes 2 🕅 No	28d. Describe ho				
- 400× =	2 Accident 3 Suicide 4 Homicida	28e. Place of Injury - At home, farm, straet, tactory, office building, atc. (Specify) 281. Location (Street end Number or Burat Ro City or Town, Stete)							
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		veician: To the best of my i	OUND AT HOME knowledge, death occurred at the ination and/or Investigation, in m		ce, and due to the ca	usa(s) and mannar a	s stated.		
vithin To the compl	29b. Signeture and trib of certifier	estaner	29c. Lic	ensa number	29	d. Date signed (Mon			
	30. Name and address of person who of	completed cause of deeth (I		O.C.M.E.		MAY 25,			
State Registrar	31. Date filed (Month, Day, Year) MAY 3 1 2000	Service 32. Registrar's Si	111 Penn Str	еет, ва.	ttimore,	Mary⊥an	a 21201		

DHMH 16 Rev 6/95

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Amended Ite	em#22 perABG784 6/		f Maryland /	Certifica			id Wellair	Reg. No.	U	1130	
Physician /Medical	Decedent's Name (First, Mic MAGDAL)			BAS	SETT		2. Dete of Month May	Day	Yaer	3. Time of Death 23:58	
Examiner	4a Facility Name (If not instituted CALVERT MEMOR						n, or Location of De		nty of Death		
Funeral	5. Social Security Number		7. Age (In yrs. lest t	irthdey) If Un	der 1 Yaar	If Under 2		Birth Day, Year)		Vert place (Stete or Foreign	
Director	225-80-4454	1□M 2ÅF	64	Yrs. Month	s Days	Hours		Day, Year)	Cou	unk	
D R	Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, To	wn or Location						10d. fnside City Limits	
The Maryla 28a-f sho notified at	MD Cood 1										
or 28a-f a notifia	10e. Street and Number			10f.	Zip Code 10g. Citizen of What Count					ntry?	
with w	3308 Cliff Tr						676		USA		
Mary light of XIX 13-0020 of 2 should be filed within 72 hours after death with the Ma th and Marinal Hygiene. The marked other than "insturil", or itema 23a or 23a-f s traumetic event, the Medical Examiner must be notified To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	dent Ever in U,S. rces? 2 X No e ates:		pecify Cub		n? (Specify Yes or Puerto Rican, etc.)	Spec	laca - Amari lack, White, city: W			
	15. Deced (Specify only high	ent's Education hest grede completed)	16	a. Decedent's U	sual Occup work done	pation during most o	of working	16b. Kind of	Business/îr	ndustry	
	Elementary/Secondary (0-12	College (1 Unk	-4or 5+)	housew		90)		ne	one		
ntal Hygined other ed other event, i	17. Father's Name (First, Middle	la, Last)				18. Mother	s Name (First, Mid				
Menta	unk					unk					
and 2 should set in mark mer traumetic	19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Ste										
mit. Pages 1 and partment of Health portant: if Nem 27 y Injury or other in	Paul Bassett/spouse P.O. Box 812 Prince Frederick, MD 20678 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 (X) Donation 5 Repertly) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State										
Physician // Medical Examiner party property of the purisher and the purisher and the purisher with the property of the proper	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	8.	RONAR'	consequence	of): 		DISEAS	25		Few minus	
at the death certify 5 by the attending petached for use as		d									
d by the detached	Part II. Other significant condi		ath but not rasulting	in the underlyin	g cause gi	iven in Pert I.		1		to the cause of death bably 4 ☐ Unknown	
E X 10											
The law requin page 2 should Completed								an autopsy arformed?			
idian: The law requires to certificate has been signs rector, page 2 should be on Be Completed by	The state of the s									☐ Yes 2☐ No	
	25. Was case referred to medi examiner?	Hospital:	a di a		Ot Ot	hor	of Deeth (Check on		N /O	w 1	
£ 2- 1-	27. Mannes of Death 1 DNatural 5 □ Pen	28a. Date o		introduction South Content All Nursing Home South Residence God Other (Specify) Time of Injury All Nursing Home South Residence God Other (Specify) Z8c. Injury at Work? 28d. Describe how injury occurred Injury More 1							
ball or Attending Physics at a part death. To allowedor: Atter this led in by the funeral d Certification: To	3 Suicide 6 □ Cou	d not be 28e. Placa	of Injury - At home, ng, etc. (Specify)	farm, street, fac			28f. Locatio	n (Street end Nu Town, Stete)	mber or Rui	rel Routa Number,	
he Hospi n 24 hou he Funer pletely III edical	29a. Certifier 1 Certify (Check only 2 Medic	ing Phyefcian: To the al Examiner: On the ba and menn	sis of exemination a	ge, deeth occurr ind/or investigat	ed at the ti on, in my	ime, date end opinion, death	place, end due to to occurred at the tin	he cause(s) and ne, date and plac	menner as e, and due	stated. to the cause(s)	
# # # E	29b. Signature and title of certi	fier M	D		29c. Licen	se number	, 7	29d. Date sig	ned (Month	0 0 1 0	
T 000	I A GALLANIA	mal .	PRANI		1)	1940	٧ /) / 0	22/200	
F 1 2 8	17111.00	Alender	0,720			. , ,					
* # # 8	30. Name end address of parson Dr. Anwar	A Lendus on who completed dus Munshi, MI	,	(Typa, Print) Ce Frede	rick	, M.D.	20678				

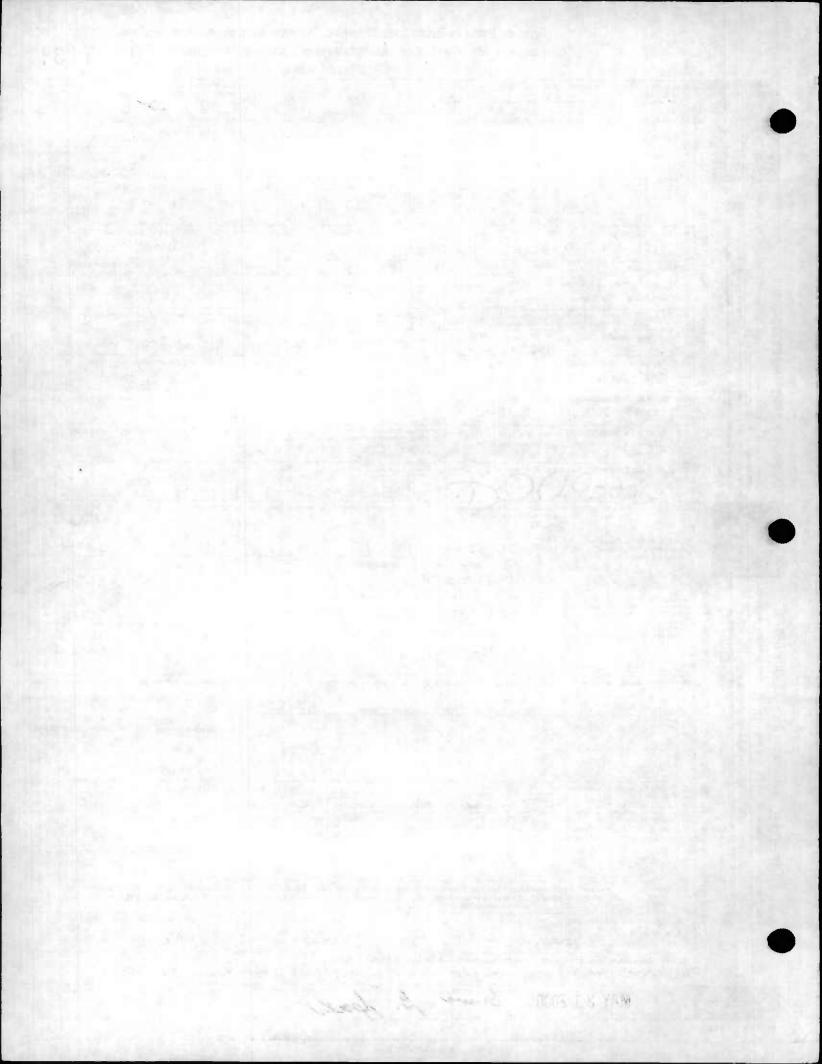


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State of Maryland / Department of Health and Mental Hygiene 00 171

			State of Marylar		ificate of			Reg. No.	1/131			
	Physician	Decedent's Nema (First, Middle, Last Doris (Theodora)			2. Data of De Month May 2	Day	3. Tima of Death 5:35 pm					
	/Medical Examiner	4e Facility Name (If not institution, giva		4b. City, Town, or								
		Washington Advent 5. Sociel Security Number 6. Se		Takoma I			gomery					
	Funeral Director		™ 2√2 F 70	Yrs.	If Under 1 Yeer Months Deys			6, 1929	9. Birthplace (State or Foraign Country) Minot, ND			
Maryland	inte, Maryland 21215-0020 s i and 2 should be lited within 72 hours after death with the Maryland Health and Mental Hygiene. The merised other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	10a. State 10b. County MN Hennep	10d. Inside City Limits 13€7es 2 □ No									
th with th		10e. Street and Number 6701 Southdale	10g. Citizen of Wr United	States								
020 NITE BITTER OSS		11. Maritel Status 1 Never Married 2 X Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2€ No If Yaa, Giva Yaar or Dates:	Armed Forces? If Yes, specify Cubar 1 ☐ Yes 25 No If Yaa, Giva 1 ☐ Yes 2505No				14. Rece Bleck, Specify:	- American Indian, White, atc. White			
1215-0 within 72 ha		15. Decedent's Edi (Specify only highest gred Elamantary/Secondary (0-12)	de completed) College (1-4or 5+)		nt's Usuel Occu ind of work done NOT use retire tive Se	pation during most of world) cretary	rking	16b. Kind of Bus				
Della		17. Fether's Nema (First, Middla, Last)	nk.	111111		18. Mothar's Nar	ma (First, Middla	, Maiden Sumeme,)			
ylar		Christ J. DeMos	S			Chrysa		Katfyg				
		19e. Informant's Name/Relationship (T) ROlland L. Blake	/ Husband		Southda	le Road,		ta Number, City or Town, Stete, Zip Code) na MN 55435				
Pages 1	755	20e. Mathod of Disposition 1	olis, MN									
Ball	Depart Import any in	21. Signature of Funaral Service Licens	seeVictor P Doda,	Jr. Ch	Name end Addr arles L Ol East R	ss of Fecility Stevens ort Avenue,	Funera Baltimor	1 Home, 3 e Maryland	Inc. 21230			
35		23e. Part1. Entar tha disaasa, or comp shock, or heert feilure. Liat only of	lications that caused ha dael one causa on each line.	h. Do not anter	the mode of dy	ng, such es cerdie	c or respiretory a	rrast,	Approximete Interval Batween Onsat and Death			
6.1	nysician Medical xaminer	Immediata Causa (Final disease or condition resulting In death)	a SEPSIS	SYNDR	OME				2 DAYS			
	<u> </u>	Tooling it down,	PN EUHON.	2115546								
cuted	nd transit	Sequentially list conditiona,	0.	or es e consequ	ence of):				3 WEEKS			
68760, ficate be axe	physicien end is the bunal-transit	Sequantially list conditiona, if eny, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events	. METASTATI		YEARS							
	9 0 5	resulting In death) Last	Due to (c	RY FAI				2 WEEKS				
B. Be	d for u	Pert II. Other significant conditions co	ributs to the causs of death?									
ords, P.O. Box	igned by the ettending be deteched for use a by Physician/M		3 Probably 4 Unknown									
Division of Vital Records, or Attending Physician: The law requires to	s been s 2 should pleted	24a.							24b. Wera autopsy findings available prior to completion of ceuse of death?			
ai Rec	page , page				- 37		10	Yes 2, No	1 ☐ Yes 2 No			
Vita	rector	25. Wes case referred to medical examiner?	Hospitaf:		- O	har	26. Place of Deeth (Check only one)					
Vision of Vita	After this of funeral direction: To	1 Yas 2 No 27. Menner of Death 1 Netural 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of injury	28c. Inju	4LI Nursing F	ursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred					
Divisi	is after deeth. Is Director: After to the in by the funeral Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homlcida determined					28f. Location (City or To	Street and Numbe wn, Stete)	r or Rurel Routa Number,			
Hospita	within 24 hours after deeth. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com		raician: To the best of my knot iner: On tha basis of examina and manner steted.									
Toth	within To th comp	29b. Signeture and title of certifier	1- 4-1-1	III E		se number			(Month, Dey, Year)			
		D. Villyamad	itya neray	ND	1 143	164		7AY- 27	2000			
		30. Nema end addrass of person who co	omplated causa of death (Itar	n 23a) (Type, P VIUE PI	rint) I.K.E., SUI	TE 208, R	OUKVILL	E, ND - 20	852			
	State Registrar	31. Date filed (Month Day 3 (ear) 200		dure S.	Some	41						

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year BACHER **Physician** CARLOS 29, 2:14 AM MARIA MAY 2000 /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl **Examiner** JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Days 1**™**M 2□ F Czech 212-08-9912 80 Republic Director April 16, 1920 Usual Rasidence of Decedent 10b. County 10a Stata 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Many 1 ☐ Yas 2 No BelCAMP HARFORD Director MARYAND il Hygiene. other then "natural", or liens 23a or 28a-f. vent, the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country's Czech Apt. 21017 1303 LIRIOPE COURT Kepublic Funeral 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar In U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status filed within 72 hours after 1 Yas 2 If Yas, Giva 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) BROKER WINC 12 18. Mothar's Name (First, Middle, Maiden Sumama) UNK 17. Fethar's Nema (First, Middla, Last) Be h and Mental Is marked of 8 BACHER permit. Pages 1 and 2 should Department of Health and Ment Important: If New 27 is marked KAREL 10 19a. Informant's Name/Relationship (Type, Print) BACHCK 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 2/0/7 LlereNA-WIFE Apt T-4 Belenno, MO NOEMI 1303 LIRIOPE COURT 20b. Place of Disposition (Neme of 20c. Location - City or Town, Stete Data 20a. Mathod of Disposition camatary, cramatory or other place) 1 Burial 2 Cremation 3 Ramoval from State 6-7-2000 CERVENE JANOVICE JANOVICE errene, 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signatura of Funeral Sarvice Licensee ZANNINO LICENSED MORTICIAN CHARLES 5. 1915 ELLINWOOD ROAD BALTO MD 23e. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heer failure. Ust only one ceuse on each line. Approximate Interval Batween Onsat and Daath Physician /Medical Immediate Ceuse (Final ARDIOMYOPATH 5 YEARS disaasa or conditior rasulting in deeth) Examiner Dua to (or as a consaquance of) Examiner 20 YEARS ORONARY The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) pue Box 68760. attending physician for use es the buna Physician/Medical Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown DIABETES Records, à 24b. Wara autopsy findings eveilable prior to complation of causa of death? 24e. Was en eutopsy performed? Completed hes 1 ☐ Yas 2 No After this certificate 1 Yes Division of Vital septat or Attending Physician: Thours after death, meral Director: After this cartificative filled in by the funeral director, pe 25. Wes casa refarred to medical axaminar? Be 26. Place of Death (Check only one) 1 Yas ≥ No Hospitel: Inpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Pending investigation 1 Yas 2 No 2 Accident 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 6 Could not be detarmined 3 Suicide 28a. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end mennar as stated.

2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and mannar stated. 29a, Cartifier 29b. Signature and little of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) RES-000 M.D. 29,2000 toma 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) WOLFE St BAlto MARYLAND 21287 North BROTMAN 600 DANIEL 31. Data filed (Month, Day, Year) 32. Registrar's Signatura MAY 31 Dener Registrar

DHMH 16 Rev 6/95

A THE RESERVE TO SERVE TO THE RESERVE TO THE RESERV

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JENNIE May 27, CARLOTTA CORSO 7:30 AM 2000 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Long Green Nursing Home Baltimore City N/A If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2 ☑ F Yrs. 88 215-16-7481 Maryland Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland N/A Baltimore City 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 2904 Grindon Avenue U.S.A. 14. Race - American Indian, Black, White, etc. 21214 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Sietus 1 ☐ Yes 2 ☐ No if Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Petro Carlotta DiFernine Gaetaua 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Phillip G. Corso 1236 Wisperingwoods Way Belair, Maryland 21014 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/31/00 Holy Redeemer Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21214 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 HArford Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onset end Death immediate Cause (Fine disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Part ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably ▲ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitai: 1 Yes 20No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 1 ZNaturai 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed P.O. Records, of Vital Physician; Division or Attending To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At

Physician

/Medical

Examiner

Directo

Funeral

Be

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23a or

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permit. Pages 1 and 2 should be file.
Department of Health and Manual Hy
Important: If Illam 27 is manked oth any Injury or other traumetic even

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altimore, Maryland 21215-0020

Registrar **DHMH 16 Rev 6/95**

State

Kamesh 31. Date filed (Month, Dey, Year) MAY 3

4 | Homicide

(Check only

29a. Certifier

29b. Signature and title of certilier

29c. License number

tc 308

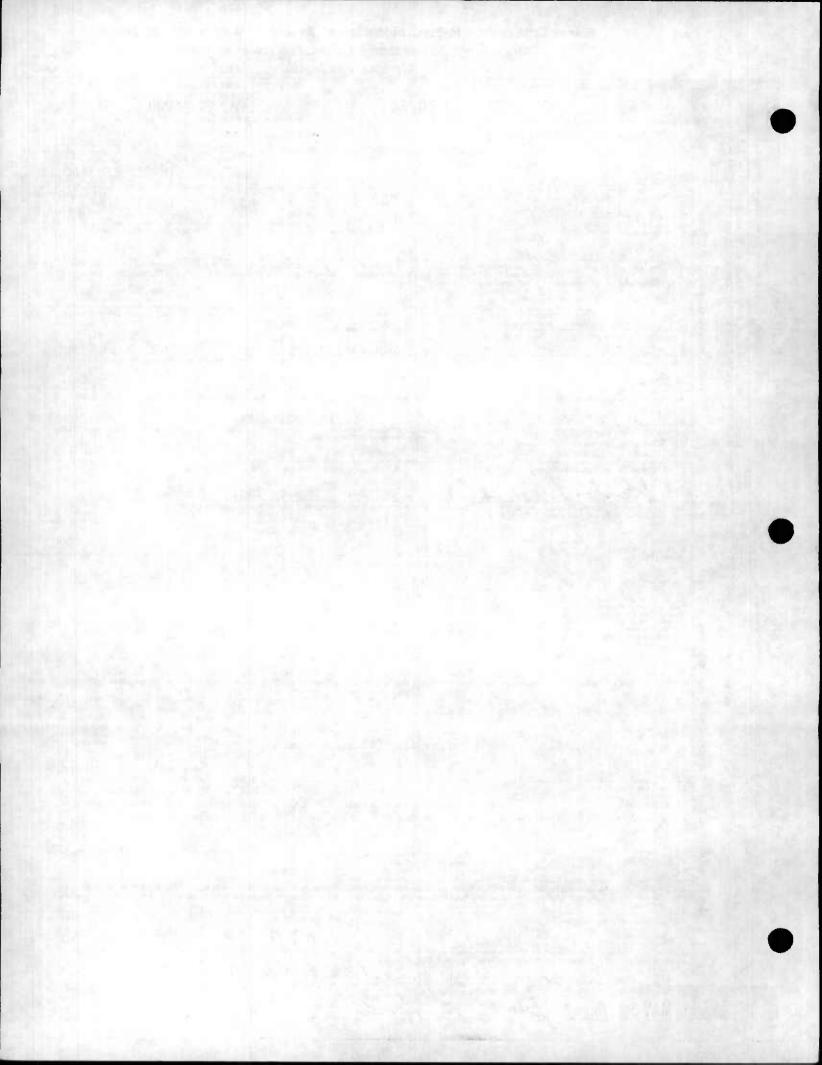
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

821 N. Eutao St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabaralli 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Name (First, Middle, Last)								Death		3. Time of Death	
Physician	Frances Jos	Month	as :	Year 2000	0105							
/Medical Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea											
	Fallston Ge	eneral H	Hospita	1.			Fallsto	on	Hari	ford		
Funeral	5. Social Security Number	f 6. Sex	7.	Age (In yrs. I		If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of F		9. Birthole	ece (Stete or Foreig	
Director	213-62-3491		IM 2X F	91	Yrs.				23,1909	Mary]	land	
pu k	Usuel Residence of Dece 10a. Stete 10b.	County		10c. City	, Town or Loc	ation				10	d. Inside City Limits	
Mary Hah					l Air						1 ☐ Yes 2 🕅 No	
the the	10e. Street and Number					10f. Zip Code			10g. Citizen of	Whet Count	ry?	
72 hours after death with the Maryler 72 hours after death with the Maryler fratterity or 18 martine and 18 martined and 18 ma	723 High Pla	ain Aver			21014			USA				
death death	11. Marifal Status		12. Wes Decede	ent Ever in U,	S. 13. V	1	Hispanic Origi	n? (Specify Yes or I Puerto Rican, etc.)		e - America		
after dea or items	1 Never Merried 2	Married	1 Yes 2	No		Yes 20 No		rueno rucan, etc.)		ck, White, e v: Whit		
d by	3 O‱idowed 4 □ D		Year or Dete	es:		**						
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel hygiene. Important: if them 27 is marked other than "natural", or thems 23a or 23a-4 show any injury or other treumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	(Specify only	ecedent's Educ y highest grade	cation completed)		16a. Deced	ent's Usuet Occu kind of work done O NOT use retire	pation during most o	of working	16b. Kind of B	usiness/Ind	ustry	
	Elementary/Secondary (0-12) College (1-4or 5+ 10th Grade N/A								Cross	~+ M-	awleat	
	17. Father's Neme (First,			56	elf Empl		s Neme (First, Midd	Cross :		arket		
	Joseph Lanasa						Jose	ephine Sar	nsone			
N Pue	19a. Informant's Neme/Re		19b. Meilin	Address (Stree	_	or Rural Route Nurr		State, Zip	Code)			
Baltimore, M went: Pages 1 and 2 pertment of Health, mortant: It feem 27 is not injury or other tre most.	Thomas Conway				723 H	igh Plai	n Ave.	Bel Air,	MD 210	14		
	20e. Method of Disposition 1 🛱 Buriel 2 Cremation 3 Removel from Stele				ece of Dispos	ition (Name of atory or other pla	ice)	Dete	20c. Location			
Pag ment: H ury o	4 Donation 5 C	Ho.	ly Cros	ss Cemet	ery	5/30/00	Brookly	n Park	c, MD			
Departicular Depar	21. Signature of Funeral S	Service License	10	1-	22.	Name end Addr	ess of Fecility	r Francisco	Homo Di			
ZQ = 2 9	Christ	ina (7. N.	elton				K Funeral Balto				
	23a. Part 1. Enter the dise shock, or heart failure	ese, or complicate. List only on	cations thet cau	sed the deeth	. Do not ente	r the mode of dy	ing, such as ca	ardiac or respiretory	arrest,		Approximate Intervel Between	
Physician											Onset end Deeth	
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) a. My o cardial Infarchian 3/									hours		
<u></u>				Due to (or	es a consequ	uence of):						
ansit	Sequentially list conditions. Due to (or es e consequence of):											
exec en an rial-tr	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of): Due to (or as a consequence of):											
tificate be executed up physicien and es the burial-transit Aedical Examiner	Cause (Disease or Injury thei initiated events consequence of): Due to (or as a consequence of):											
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at the death cer d by the attendin letached for use Physician/N		d										
the a the a shed for the district of the distr	Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Di	d tobacco uas co	ntributs to	the cause of death	
ad by detac	Renal Failure							1[1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Offiknow			
The law requires that the death cercate has been signed by the attendir page 2 should be defached for use Completed by Physician/A	7-710003 -7-1010								4a. Wes an eutopsy 24b. Were autopsy find		re autopsy findings	
been should								pe	rformed?	med? eveilable prior to completion of cause		
5 2 G									01		eeth?	
certificate has rector, page 2 Be Comp	1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat 26. Place of Deeth (Check only one)									10	Yes Z No	
	examiner?	_	ospitel: 1 🗆 Inp	atlent 2124	R/Outpatient	3□ DOA O	hor	ing Home 5 Re		er (Snecih	1	
To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	27. Menner of Death		28a. Dete of (Month,		28b. Tima of	28c, Inju			e how injury occur			
Attanding Physician: r death. cetor: After this certific by the funeral director. filcation: To Be (2 Accident	Pending investigation	(MORIT),	Doy rear)	Injury		Yes 2 □ No	0				
r Atte ter de recto 1 by th	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Plece of building	Injury - At hor	me, farm, stre	et, factory, office			(Street and Numi	ber or Rural	Route Number,	
the Hospital or Attanding P thin 24 hours after death. the Funeral Director: After I mplately filled in by the funeral Medical Certification:												
Hospital or 24 hours afte Funeral Dir stely filled in stely filled in	(Check only 2 M	ertifying Physi ledical Examin	ician: To the beer: On the basi	st of my know s of examineti	vledge, deeth	occurred at the t	ime, date and opinion, death	place, and due to the	e cause(s) and m	anner es sta and due to	ated. the ceuse(s)	
within 2 To the P complete	one) 29b. Signature and title of		and manner	stated.			se number		29d. Date signe			
5 ½ 5 8	250. Signature and title of	Certifier	18m	100	MA				Mac.) ()	000	
/			-0100	1001	10		33642		18144	6/2		
5	30. Neme and address of	person who cor	mpleted cause of	of deeth (Item	23e) (Type, F	(ETIP	10	BesAL	MD 21	CIY		
	2011	1 - /	11400		() /111	11/1/11	1	11.11	11/11	/		
State	31 Mate Med (Month, Day	(, Year)	32. Reg	Istrar's Signet	ure							

ORIGINAL

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Physician 27, 1:00 P.M Mary Elizabeth Campbell May 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Pasadena 167 Waldo Road If Under 24 Hrs. Dete of Birth (Month, Dey, Year) If Under 1 Yeer 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1□M 2□X Yrs Director 216-18-3696 3, 1924 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ X00 Director Anne Arundel Pasadena MC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. Items 23s 167 Waldo Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Introduction if them 27 is merked other than "natural", or frem any injury or other traumatic avent, the Medical Property. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify þ 3 Widowed 4 Divorced White Completed 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 6th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Bayline Mary Frederick Michael 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 167 Waldo Road Pasadena, Md. 21122 Cynthia Campbell (Daughter) 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Md. Veterans Cemetery 5/31/00 Crownsville, Maryland 21. Signature of Toheral Service for 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Approximate tnterval Between Onset end Death 23a. Pert1. Enter the disual shock, or heart feiture heatiens that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? Unknown been signed by should be detac 1 Yes 2 No 3 Probably Records, p 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24e. Wes en eutopsy 1 ☐ Yes 2 1000 2000 1 Yes certificate Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 200 No 1 Inpatient Certification: To 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 1 Metural 5 Pending investigation death. 1 Tyes 2 No 2 Accident Director: / 6 ☐ Could not be within 24 hours after de To the Funeral Directo compleiely filled in by th 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 24 hours after of 4 ☐ Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the To the To the 29c. License number 29b. Signature and title of certifie 29d. Dete signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

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32. Registrar's Signeture

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

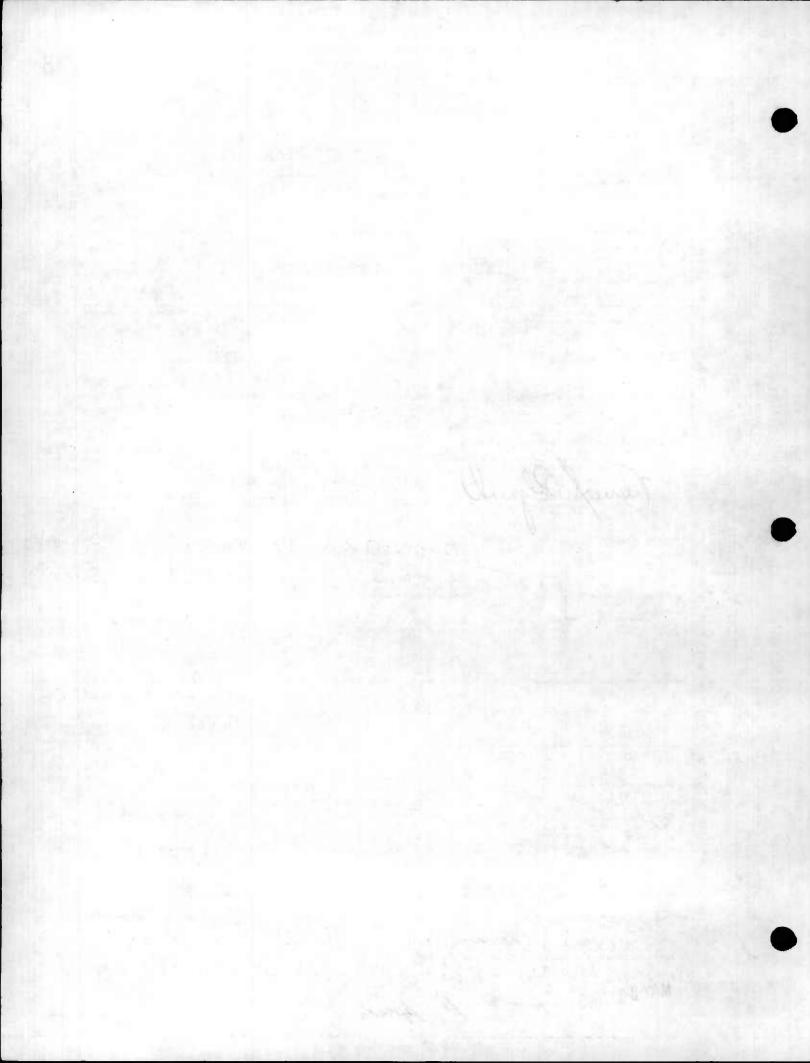
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May, 30, 2000

OFENBURME, Maryland



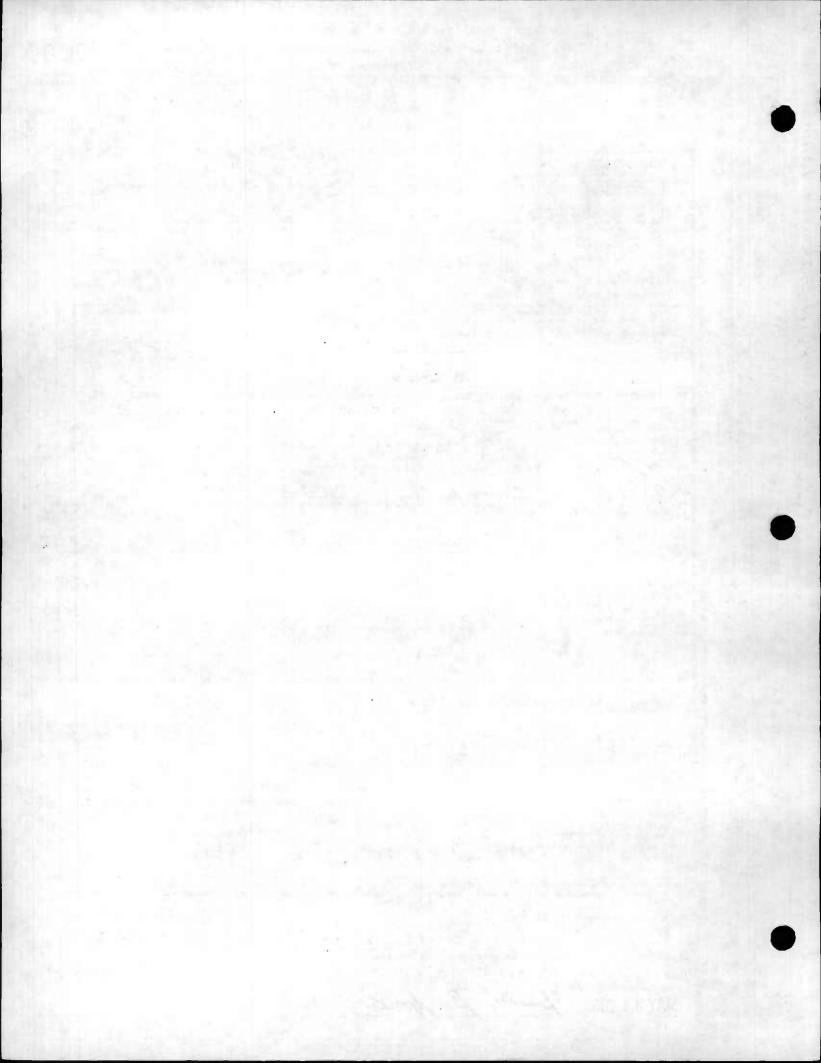
		1. Decedent's Nem	e (First, Middle, Las	st)					2. Dete of Dea	th		3. Time of Death	
	Physician	PIERVIIV CODLENZER MAI ZO, ZO									Year	5:30 AM	
	/Medical Examiner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death											
	Funeral Director	5. Sociel Security N 214-16-9		ex 7. Ag	ge (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days			Year)	9. Birthp Cour	place (Stete or Foreign htry) MD	
9		Usuel Residence of											
Maryla	art show illed at	MD	BALTIMOI	RE		Town or Local IMORE	ation				1	1 ☐ Yes 2 🔯 No	
6	or 28a-1 s be notified Director	10a. Street and Nur	mber			10	10f. Zip Code		1	0g. Citizen of	What Cour	ntry?	
6		11 SLAI	DE AVENUE	#608			212	80		U.S.A.			
320 rs ether dea	if, or tems 23 caminer must by Funeral	11. Merital Stetus 1 ☐ Never Merri 3 ☐ Widowed	ied 2 Married 4 Divorced	12. Wes Decedent Armed Forces? 1 XXYes 2 If Yes, Give Yeer or Detes:	7	H	/as Decedent of Yes, specify Cul ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		ck, White,	American Indian, White, etc. WHITE	
2 20		10	15. Decedent's Ed			16a. Deced	ent's Usuel Occu	pation		16b. Kind of B	usiness/in	dustry	
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0	avent, Be C	17. Fether's Neme	(First, Middle, Last)			INSUR	ANCE AGE		ne (First, Middle,			77	
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and series	and a	19e. Informent's Ne	eme/Reletionship (Type, Print)	200	19b. Meilin	Address (Stree	et and Number or Ru	ural Route Numbe	r, City or Town	Stete, Zip	Code)	
Z pu	n 27	SYBIL C	OBLENZER	/ WIFE				TUE #608 -	- BALTIMO	ORE, MD	2120)8	
Pages 1	ant: If there ary or oth			Removel from State	cerr	netery, crem	ition (Name of etory or other pla HEBREW	CEMETERY	Dete 5/28/00	20c. Location - BALT		own, State E, MD	
Balt	Importa any inje	21. Signified of Fu	neral Service Light	500			Name end Addr	ess of Fecility				S., INC.	
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EX	aminer	resulting in deeth)		a	Due to (or e	s a conseq	uence of):					2	
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8 0		cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of):											
ox 68/60	0 6	resulting in death) i	Last	d	Due to (or a	s a consequ	ience ot):						
n f	0 - 0	D. 411 Oct 1 - 10							L ago miles		1		
requires that the de	ed by the edelached f	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. CONOMINY ANTERY DISENSE 1 Yes 2)35No 3 Prof. Peripheral NASCULAR DISEBSE 24a. Wes an autopsy performed? 24b. Wing average given in Part I. 1 Yes 2)35No 3 Prof. 24a. Wes an autopsy performed?										bably 4 Unknown	
Hecords,	sale hes been signed by the page 2 should be detached Completed by Physic	peri	pheral	PAS	cula	rd	ise as	e		24a. Wes an autopsy performed? 24b. Were autopsy findin aveilable prior to completion of cause of death?			
The lew	i certificate hes t lirector, page 2 s o Be Compli								1 Yes 2 No 1 Yes 2				
VITAL	certificate he rector, page Be Com	25. Wes case refer	red to medical					26. Place of Dec	eth (Check only or				
o y	E -	examiner? 1 Ves 254 27. Menner of Death 1 Neturel		Hospitel: 1 Inpation 28a. Dete of Inju (Month, De	ury 2	VOutpatient Bb. Time of Injury	3□ DOA O		forme 5 ☐ Resident 28d. Describe h			m Hospice	
OIVISION or Attending	al Director: After the din by the funeral Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Pleca of in				Yes 2□No	28f. Location (S City or Tow		ber or Run	al Route Number,	
To the Hospital or Attend	To the Euneral Directors completely filled in by the Medical Certifical	29e. Certifier (Check only		ysician: To the best	of my knowle								
The H	the Funer npletely fill	one)		iner: On the basis o end manner st	examinetion	H end/or Inv							
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	40	30. Name and addre	ess of person who	Completed cause of		3a) (Type, F 7 & 1	Print) N. Ch	sdos avle, St	. Bal	to on	d 2	1204	
	State	31. Dete filed (Mont		32. Registr	rer's Signetur	9						7	
	Registrar	MAY 3 1	2000	reprint	13.	spor	C)						

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

17136



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month 4:05A.M May Josephine L. 30 2000 Cherrey 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Kosedale Center tranklin Square Hospital If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 1□ M 20%F Days Yrs. 164-24-2880 70 Jan. 19, 1930 Pennsylvania Usuel Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits Maryland Baltimore 1 Yes 2 XNo Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2105 Hawthorne Road 21220 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bustness/Industry Elementery/Secondary (0-12) College (1-4or 5+) Administrator Steel Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Stanley Lemanski Stella Machinski 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Cherrey (son) 16763 Golf View Drive, Weston, Florida 33326 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 6/2/2000 Baltimore, Maryland 4 □ Donetion 5 □ Other (Specify) Holly Hill Mem. Gardens 22. Nama and Address of Facility 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximata Intervat Between Onset and Death 23e. Part 1 Ther the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Immediete Ceuse (Final disease or condition resulting in deeth) · Metastatic Lung 6 Months Due to (or as a consequence of): Hypernephroma Sequentially list conditions, if any, teeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es a consequence of): Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1)X Yes 2 No 3 Probably 4 Unknown Emphysema, Diabetes, Congestive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Heart Failure 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

show.

Nem 27 is marked other than "natural", or itema 23a or 28a-1 show other treumetic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 te marked other than "natural", or item eny injury or other treumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0020 herrey, Sosephine

Physician/Medical Examiner

attending physician and for use as the bunal-tran Certification: To

Completed by Be

The lew requires that the death certificete be axecuted P.O. Box 68760, Records. Division of Vital Hospital or Attending Physician: After n 24 hours after death. he Funerel Director: Afte pletely filled in by the fun

Medical To the Hosp within 24 hos To the Fune completely fi

State Registrar

31. Dete filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signatura and titla of certifier

29c. License number

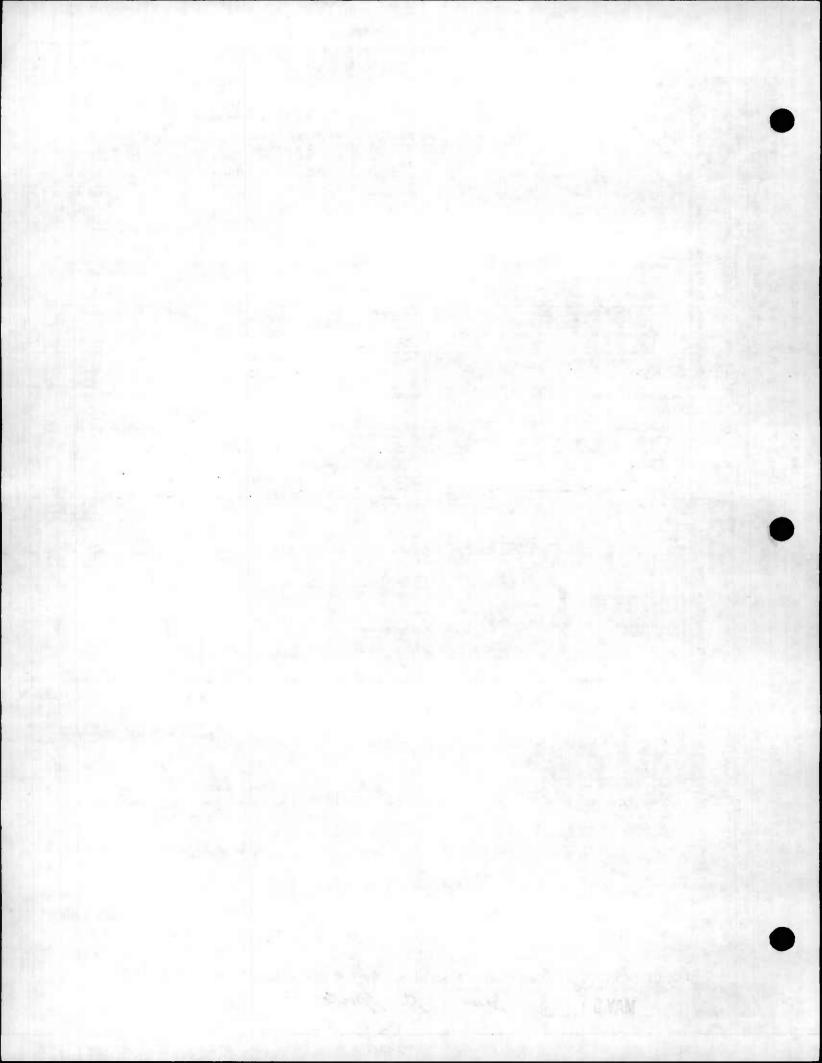
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) May 30, 2000

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Burke 9000 Franklin Square Drive Baltimore, MD 21237 32. Registrar's Signature

MAY 3 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #23a PER MD G783 5/31/2000 AH 1. Decedent's Neme (First, Middle, Last) 2. Dale of Death 3. Time of Death Physician JOSEPH DOWNEY MAY 6,2000 7:30 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A CANTON HARBOR FUTURE CARE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JAN. 17, 1922 5. Social Sacurity Number If Under 1 Year 9. Birthplace (Stata or Foreign Country) MARY LAND 7. Aga (In yrs. last birthday) **Funeral** Months Days Yrs. 78 215-18-3460 Director Usual Residence of Decedent 10s State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 X Yas 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 3013 FAIT AVENUE U.S.A. 14. Race - American Indian, 21224 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ② () No If Yas, Giva Yaar or Dates: Heme Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Meritel Stelus Bleck, White, etc. filed within 72 hours effer Nevar Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0020 natural', or 1 ☐ Yas XX No Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Hygiene. Elemaniary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled wit Department of Health and Mantel Hygiern Important: If item 27 is marked other tha eny fulury or other treumatic event, the DRGs. 8 INSPECTOR BALTO, CITY LIQUOR BOARD 17. Falhar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH J. DOWNEY ANNA V. HENRY 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) ELAYNE TROMPETER/ NIECE 3110 PREAKNESS DRIVE, FALLSTON, MARYLAND 21047 20b. Place of Disposition (Name of cematery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stala 1 Burial 2 Cramation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 5/10/00 BALTIMORE, MARYLAND 21. Signetura of Funaral Service Licensee 22. Name end Address of Fecility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET BALTIMORE MARYLAND 21224 23e. Part1. Enlar Iha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Enysician Immediate Causa (Final disease or condition resulting in death) /Medical Numeria £'xaminer Due to (or as a consequence of): STROKE Physician/Medical Examiner 110770 Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed evants rasulting in death) Last ettending physicien and for use es the burial-tran Dua to (or as a consequence of): ARTERIO SCLEROTIC VASCULAR DISEASE Box 68760. Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? ate hes page 2 s 20No 1 ☐ Yes 1 ☐ Yas 2 2 No certificate al or Attending Physician: The safter death.

N Director: After this certificated in by the funeral director, pagins by the funeral director, pagins and in by the funeral director, pagins and the funeral director, pagins and pagins and pagins and pagins. 25. Was casa rafarred to medicat 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending invastigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital

State

DHMH 16 Rev 6/95

within 24 hours a To the Funeral C completely filled

To the To the To the I

Medical

Registrar

of person who completed causa of death (Ilem 23a) (Type, Print) 30 Nama and address 31. Data filed (Month, Day, Year) MAY 3 1 32. Registrar's Signatura

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

6 Could not be datamined

3 Suicida

29a. Cartifier

4 Homicida

(Check only

29b. Signature and title of certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

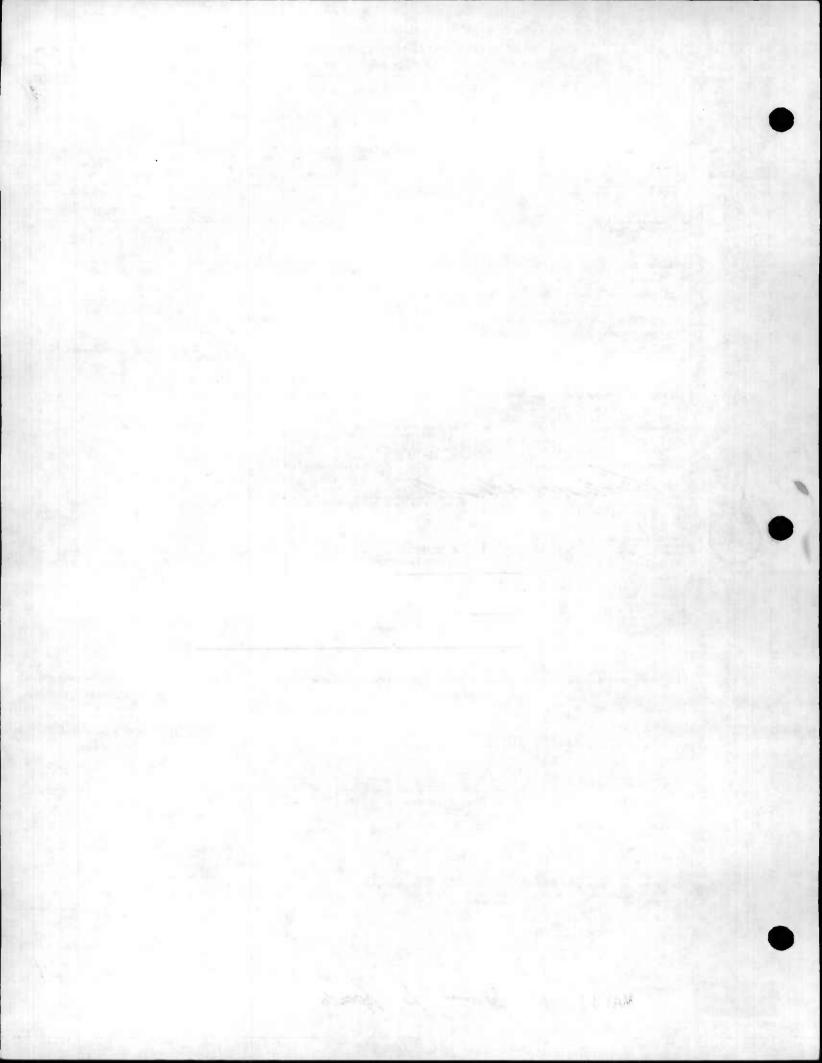
Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

00

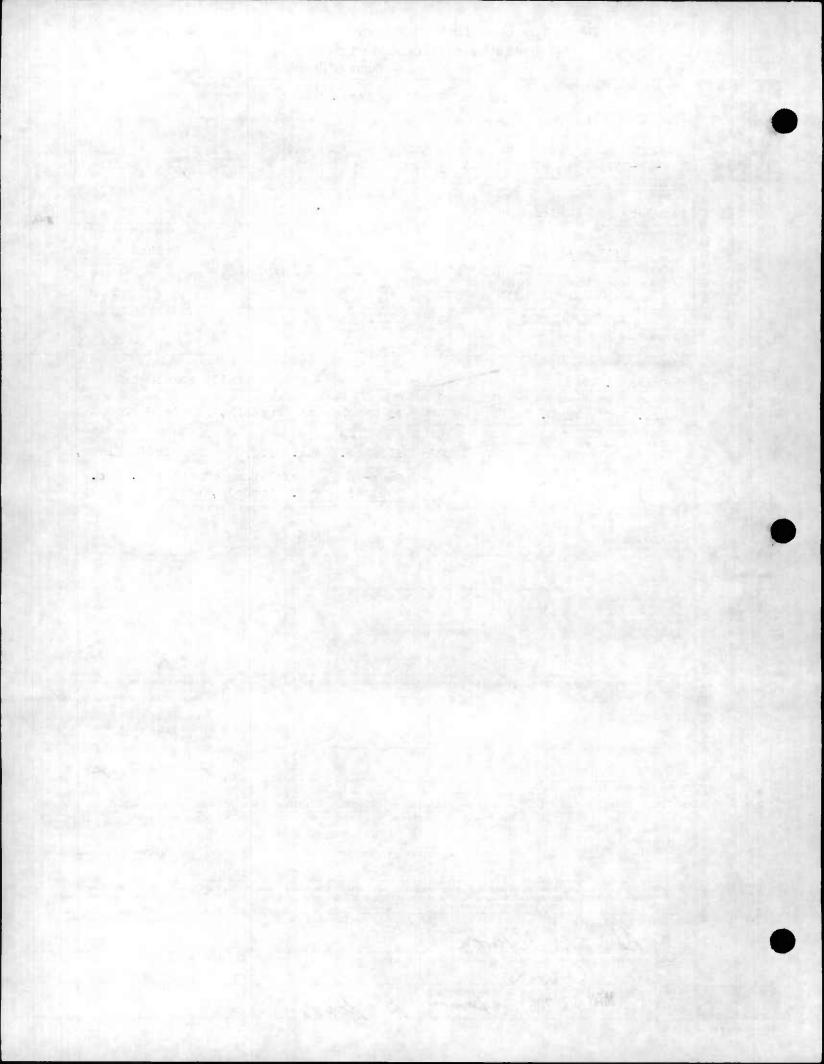
Location (Street and Number or Rural Route Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)



hysician	1. Decedent's Name (First, Middle, La	Richard	avis	2. Date of Deat Month	Day Year	3. Time of Deeth						
Medical	4a Facility Name (If not institution, gir	ve street and number)	4b. City, Town, or	May Location of Death	26 2000 4c. County of Dea	7:22 A.M.						
xaminer	2128 Willow Sprin		Dundalk		Baltim							
	5. Social Security Number 214-28-7132 6. Sex 1 Morths 1 Morths 1 Days 1											
Director	Usual Residence of Decedent 10a. State 10b. County Maryland Ba.	ltimore 10c.	City, Town or Location	Dundalk			10d. Inside City Limits 1 ☐ Yes 2 No					
	10e. Street and Number 2128 Willow Spa	ring Poad	10f.	Zip Code 21222	1	Og. Citizen of What C						
	11. Marital Status 1 Nevar Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☑ Yes 2 ☐ No		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puar 2 No Specify:	Specify Yes or No- to Ricen, etc.)	14. Race - Am Black, Whi	arican Indian,					
	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's U (Give kind of life. DO NO	suel Occupation work done during most of wo Tuse retired)	rking	16b. Kind of Business						
	Elementary/Secondary (0-12) 7 Years 17. Father's Neme (First, Middle, Lasi	Collega (1-4or 5+)	Tin M	ill	me (First, Middle, I	Steel I	ndustry					
	Frank H. Davis					Hardinger						
	19a. Informant's Name/Relationship Mrs. Bettymae				ural Route Number	, City or Town, State,	Zip Code)					
	20a. Method of Disposition		Place of Disposition (I	Vame of		20c. Locetion - City or						
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, crematory o	fem. Gdns. 5/3		Middle R						
	21. Signature of Funeral Service Lice		22. Nama Duda-	and Address of Facility -Ruck Funeral	Home of							
	7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1: Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feliure. List only one ceuse on each line. Approximate intervel Between											
9	Immediate Cause (Final disease or condition resulting in death)	8	ND SHOTGUN	WOUNDS OF THE	E HEAD		Onset and Death					
Sequentielly list conditions, if any, leading to immadiate cause. Enter Underlying Couse (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of												
										Part II. Other significant conditions	contributing to death but not r	asulting in the underlyin
					10Y	es 2 No 3 1	Probably 4 Unknown					
			300		24e. Was e perfori		Were autopsy findings available prior to completion of ceuse of death?					
-		*			1584		VSCYes 2□ No					
-	25. Was cese referred to medicel examiner? XXYes 2 □ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpetient 3☐	Other:	ath <i>(Check only on</i> Home 5 ☐ Reside		ecilyat scene					
	27. Manner of Death 1 Neturel 2 Accident	28e. Date of Injury FOMOND: Day Year,	FOUND: A	28c. Injury at Work? 1 ☐ Yas 2 ☐ No		SHOT HIMS	SELF					
	3 Suicide 6 Could not be determined	5-26-00 28e. Plece of Injury - Albuilding, etc. (Soe RESID		tory, office		treet and Number or F n, State) 2128 N OR DUNDALK	Gural Boute Number INC., MD RD.					
ē				ed at the time, date and plection, in my opinion, deeth occ								
edical Certification:				29c. License number	2	9d. Date signed (Mor	nth, Day, Year)					
	29b. Signeture and title of certifier	& Chutero										

Registrar DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗋 🦳 AMENDED ITEM #9 PER FH G784 6/6/2000 AH Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Daath Month 4 Year **Physician** RUBYM. AIX OW

4a Facility Name (If not institution, give street and number) 1215/2 30 2000 /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner MEDICAL CENTER BALTO CITY SALTO CITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign WEST VIRGINIA 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 1 M 250F 67 211-26-4060 Director 13/32 Usual Residence of Dacedant with the Marylend 10d. Inside City Limits 10c. City, Town or Location them 27 is marked other than "natural", or itema 23a or 28a-f show other treumetic event, the Macical Examiner must be notified at 1 Yes 2 □ No Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1417 Light Street 21230 U.S.A. Funeral Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 11. Marilal Status permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or ite any injury or other treumsite event, the Medical Execution 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Spacify only highest grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 20 Collins Cleo Clarence Garten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 1325 Old Mountain Road, Pasadena, Maryland 21122
Loc of Disposition (Name of Date 20c. Location - City or Town, State Roger D. Collins Son 20a. Method of Disposition

1. Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 6-1-00 Marriottsville, Crestlawn Cemetery 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Fundral Service L 130 East Fort Avenue, Baltimore, Maryland 21230 art1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one contact in a contact line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final VENTRICULAR FIRRILLATION diseasa or condition rasulting in death) Examiner Due to (or as a consequance of) Examiner the buriel-transit certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequenca of): pue attending physician for use es the burie Physician/Medical Due to (or as a consequence of): signed by the a Part fi. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 ♥ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yas 2 No Division of Vital 25. Was casa raferrad to medical examiner? Be 26. Piace of Daath (Chack only one) Top Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Inpatient 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Dascribe how tnjury occurred Certification: 1 Natural 5 Pending invastigation death. 1 Yes 2 No 2 Accident ofter death Director: the Funeral Direction of filled in by the 6 Could not be determined 3 Suicide 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - Al home, farm, street, factory, office building, atc. (Specify) 4 Homicida 6 29a. Cartifiar 🗷 Certifying Physictan: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number May 30, 2000 D0054620 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 115 METAICAL CTR. we ser mercy J LAWrence 31. Date filed (Month, Day, Year) MAY 3 1 2000 32. Registrar's Signature State Registrar

A Lake week on Year toon you'll will be the the Maria Anna Carlo Car Maria Anna Carlo Car yes the water of the street TOTAL CONTROL OF THE PARTY OF T in the many with the state of the

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death DUFF Year **Physician** ROSE 5-15 PM 26 2000 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner NORTH WEST RANDALLSTOWN BAUTIMORE If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2XX Deys 137-10-7365 Yrs Director 84 2/21/1916 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 No Director 28a-f Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 1217 White Mills Road 21228 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ঐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, Whita, etc. 72 hours after 1 □ Never Merried 2 □ Married "natural", or l Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: 3€XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middla, Maiden Surneme) Be permit. Pages 1 and 2 should be fi Oepartment of Health and Mental is important: if them 27 is marked of any injury or other traumatic ave-George Docherty Catherine (Unknown) 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Paradiso 1217 White Mills Road; Catonsville, MD 21228 saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 5/31/00 George Washington Mem. Paramus, NJ 21. Signature of Funeral 9 22. Nama and Address of Facility elmer Joseph Kellner Loring Byers Funeral Directors Inc. 8728 Liberty Road; Randallstown, MD 21133 Approximate Intervat Between Onset and Deeth 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on aech lina. **Physician** ATHEROSCIEROTIC CARDIOVACCULAR DISEASE tmmediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events Due to (or es a consequence of): Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or es a consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4/2 ata has been signed page 2 should be de þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes certificata Division of Vitai or Attending Physician: 25. Wes case referred to medical examiner? å 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Yas 2 No 1 Inpatient this 27. Member of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending efter death. 1 TYas 2 TNo 2 Accident investigation 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours e Funeral E Hospital Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 ş

State Registrar

29b. Signeture and title of certifier

31. Date filed (Month, Day, Year)

MICHAEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROTKKIN

2000

DHMH 16 Rev 6/95

ORIGINAL

5401 OUD DOURT

32. Registrar's Signature

29c. License number

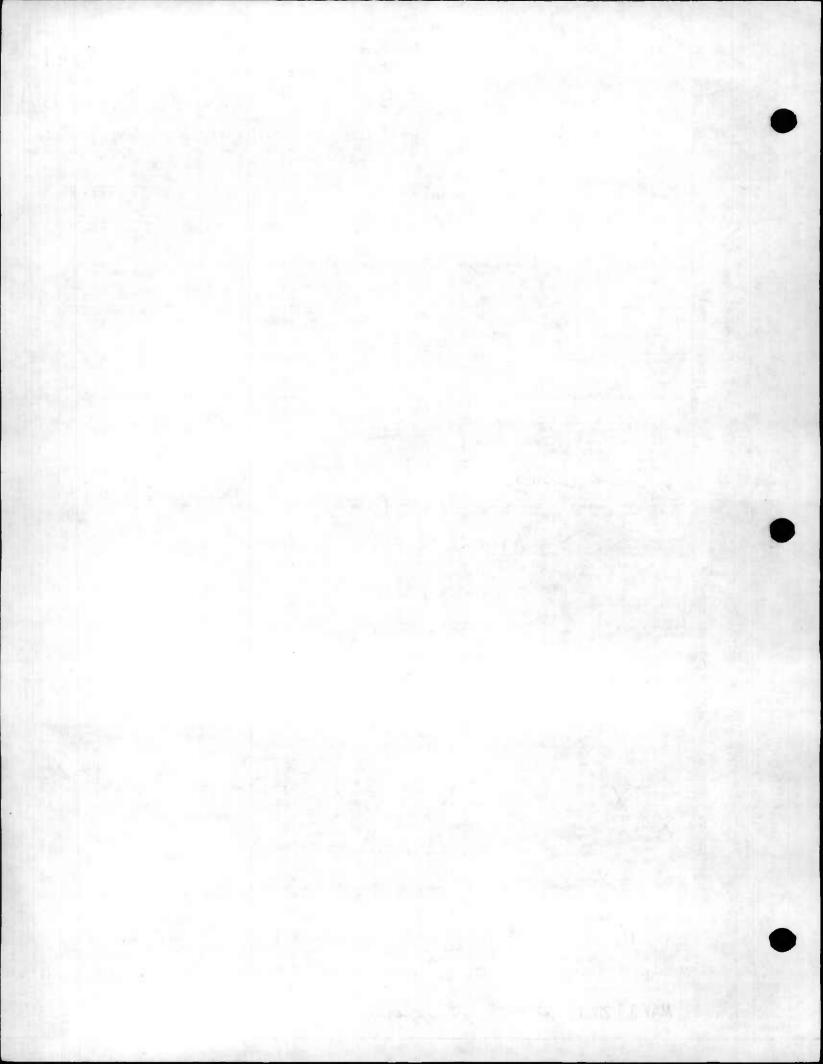
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29d. Date signed (Month, Dey, Year)

Man

RANDALLITUN

26, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Yeer Month **Physician** JOYCE 11:26 AM DOBSON MAY 26 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death City Examiner BALTIMORE BALTIMORE 6-00D SAMARITAN HOSPITAL H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1□M 2\ F Director 217-50-9711 2-13-1947 MD. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or hams 23s or 28s4 show traumetic svent, one Medical Examinar must be notified at MD. ANNE ARUNDEL ANNAPOLIS TYPES 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10a, Street and Number 83 W. WASHINGTON ST. 21401 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2√ No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-SECRETARY CHURCH permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic avanta 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be GEORGE JOHNSON DOROTHY ANNE BROOKS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOY DOBSON (DAUGHTER) 6627 TOUCHSTONE CT. BALTIMORE, MARYLAND 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-5-2000 ANNAPOLIS, MARYLAND ANNAPOLIS MEM. GARDENS 4 Donation - Other (Specify) 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A. 21. Signeture of Juneral Service Licensee recol 821 WEST ST. ANNAPOLIS, MARYLAND 21401 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final ENCEPHALOPATHY ANOXIC disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner HEMORRHAGE INTRACEREBRAL burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial UNCONTROLLED HYPERTENSION Physiclan/Medical Due to (or es a consequenca of): signed by the attending I the deteched for use as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably WUnknown þ 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of cause has 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medicel exeminer? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 27. Manner of Death 28b. Time of Injury Certification: 28a. Dete of injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Pending investigation 1 Yes 2 No a for Attendi s after death. I Director: A d in by the fo 2 Accident 6 Could not be determined 3 ☐ Suiclde 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Decritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one)

To the Hospital of within 24 hours at To the Funeral D completely filled in Registrar

DHMH 16 Rev 6/95

The law requires that the death certificate be assecuted

Box 68760,

P.O.

of Vital Records.

Division Attending

death.

with the Maryland

filed within 72 hours after

Maryland 21215-0020

Baltimore.

State

29b. Signature end title of certifier

Dia

31. Dete filed (Month, Day, Year) 32. Registrar's Signature MAY 31

M. D.

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

A 10TA COD SAMARITAN HOSPITAL

COLOR SAMARITAN HOSPITAL

COLOR SAMARITAN BAUTIMORE, HOSPITAL, SOOI WERE, MARYLAND - 21239. oaks

12561

29d. Date signed (Month, Dey, Year)

MAY 26,2000

29c. License number

ORIGINAL

Please Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month EDWARDS 4:45 AM PAUL 2000 MAY 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth 4306 KATHLAND BALLIMORE | H Under 1 Yeer | H Under 24 Hrs. | 8. Dete of Birth (Month), Deys | Hours | Min. | (Month), Dey, Year) | /2 - /2 - 24 9. Birthpleca (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Sex 1 M 2 F Months 75 239-30-9395 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 Yes 2 No BALTIMORE 10f. Zip Code 10g. Citizen of Whet Country? 10e, Street and Number 4306 KATHLAND 21207 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 Never Merried 2 Merried Specify: BLACK 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Detes 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CRANE OPERATOR TERMINAL OPERTICALS 10 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) JOHN KINSE ERNESTINE COLEMAN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 4306 KATHLANDANE BALTO, MD 21207 EDWARDS TESSIE 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete 20a. Method of Disposition GARRISON FOREST 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 6-5-00 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility HOWELL FUNERAL 140ME mid 4600 LIBER 4201 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immedieta Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel; 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 \$\ Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menger of Death 28d. Describe how Injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier

Box 68760. PO Records, of Vital Hospital or Attending 24 hours after death. Division To the Hospital within 24 hours a To the Funeral Completely filled

Physician

/Medical

Examiner

Funeral

Director

items 23s or 28s-f show iner must be notified at

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "na any injury or other traumatic event, to a Health one.

Physician

/Medical Examiner

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Examine

Physician/Medical

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filled in by the f

21215-0020

Baltimore, Maryland

Director

Funeral

by

Completed

Be

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year)

MIGUEL

29b. Signeture end title of certifier

adv

SADOVNIK

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture

1838

GREEN

29c. License number

TREE

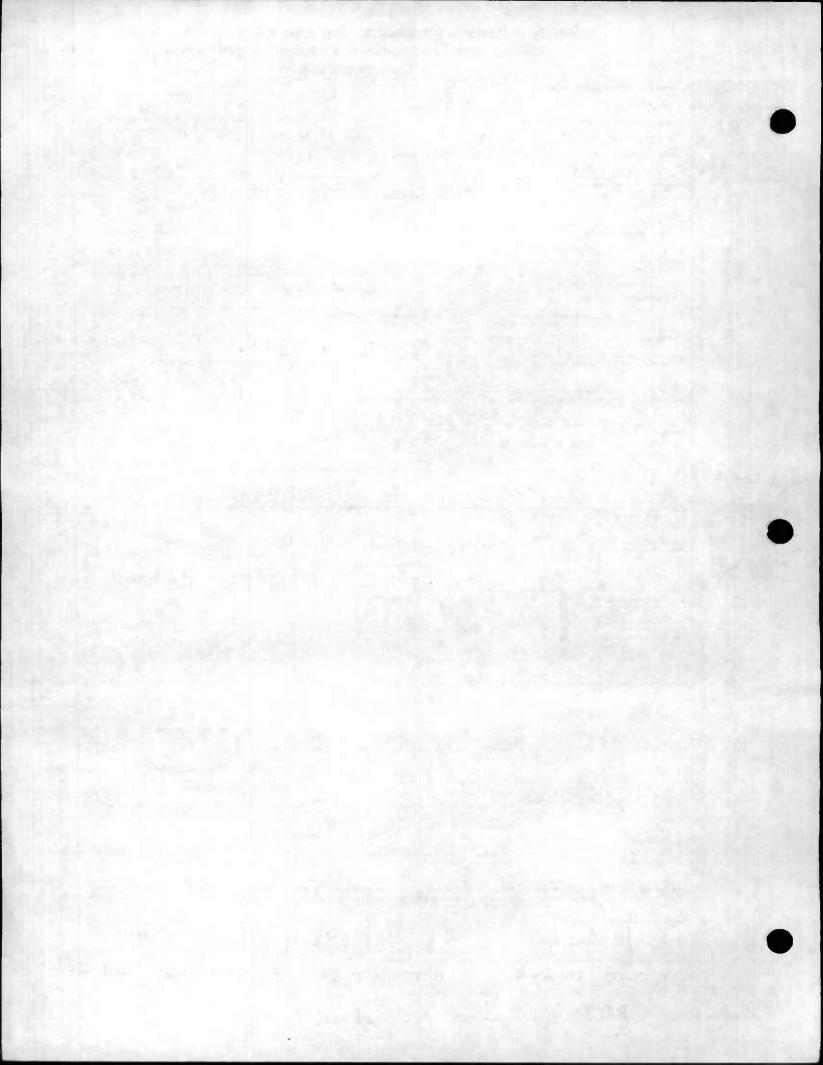
29d. Date signed (Month, Dey, Year)

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31/01

BACTIMORE

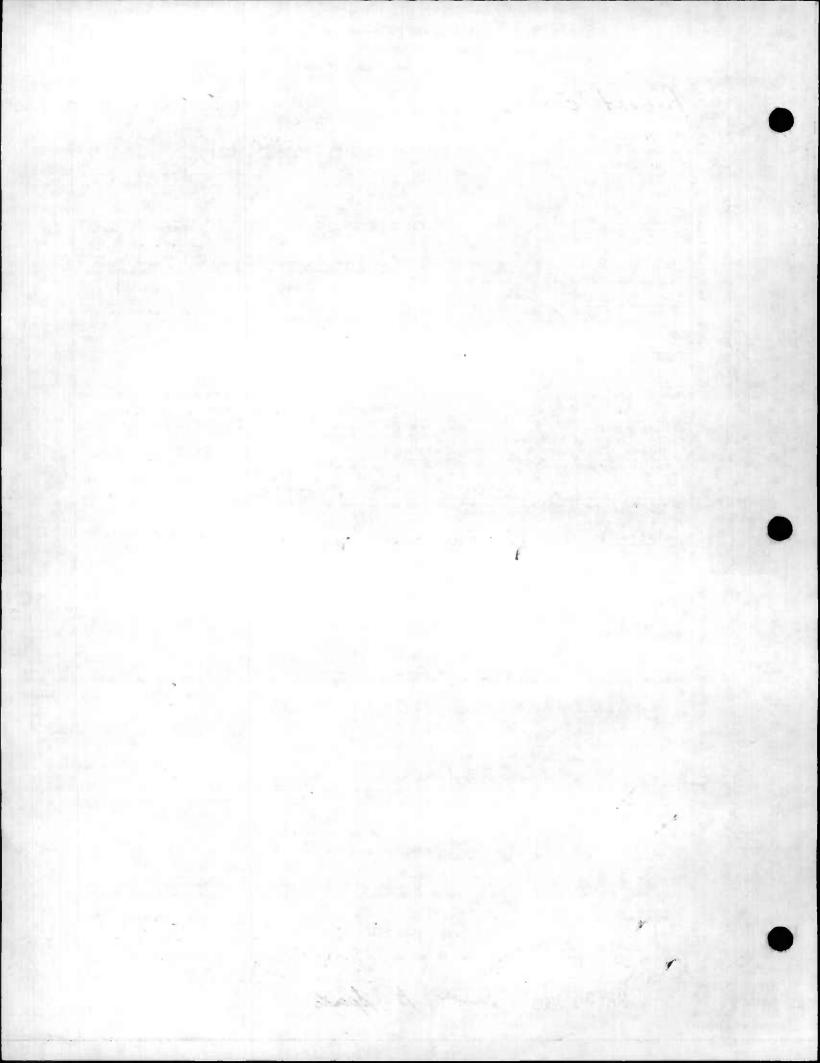
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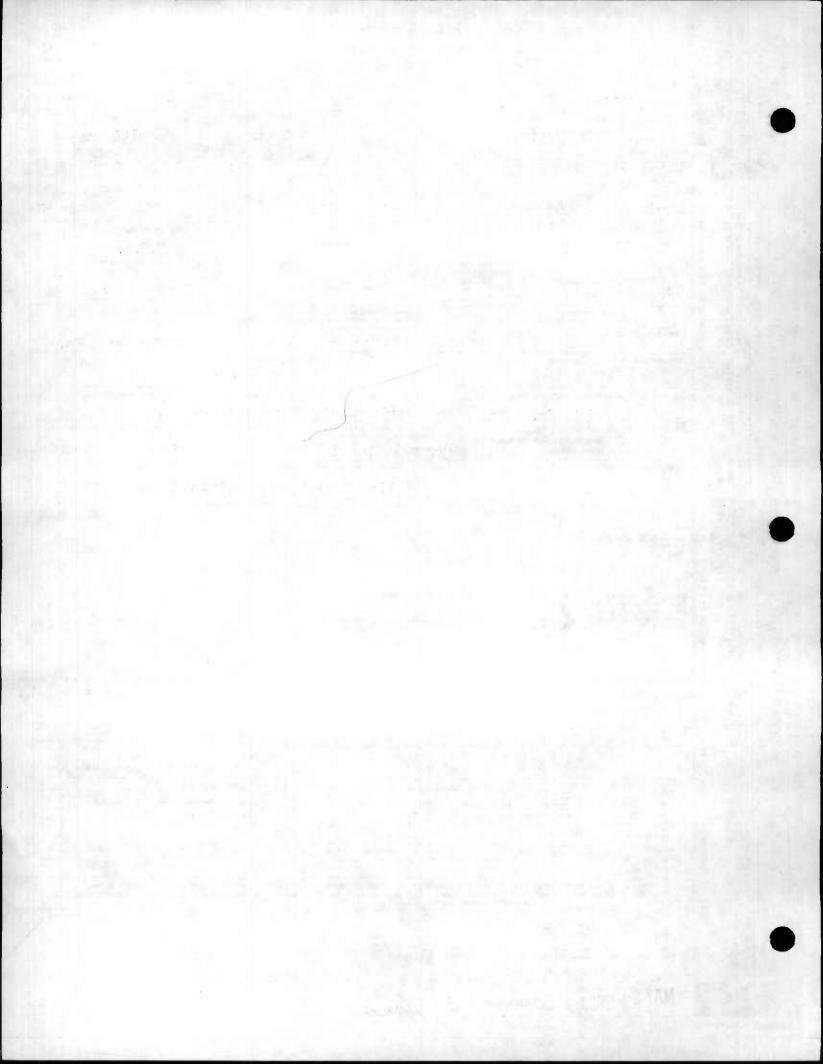
Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Year Physician tvans Sober 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ravenwood Nursing Center Baltimore City If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 46 Yrs. 6. Sex 1 XM 2 ☐ F 8. Dete of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) Funeral Months Days Director 215-60-3123 25 1953 10 North Carolina Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits Maryland N/A 1 A Yes 2 No Baltimore City Directo 10e. Street and Number 5233 Cuthbert Avenue 10f. Zip Coda 10g. Citizen of What Country? 21215 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Merried 8 1 Yes 2 No Specify: à Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. Do NOT use ratired) Laborer 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Self-employed 8th 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Surnama) Pages 1 and 2 should be I nent of Health and Mental I ent: If item 27 is marked or William Evans Mamie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mamie L. Evans/Mother 5233 Cuthbert Ave. Baltimore, Maryland 21215 Baltimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 5/27/00 Catonsville, Maryland 22. Name and Address of Facility
William C. Brown Community Funeral Home 21. Signature of Europe wellen 1206 W. North Avenue, Baltimore, Md. 23a. Part1. Enfar the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one causa on each line. Approximate tntarval Batween Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Que to (or as a consequenca of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last use as the bunal-tran Due to (or as a consequence of): and sate has been signed by the attending physician page 2 should be detached for use as the bunal P.O. Box 68760, Due to (or as a consequenca of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown Division of Vital Records, δ 24b. Wara autopsy findings evallable prior to complation of causa of daeth? Be Completed 24a. Was an autopsy this certificate has 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; g 25. Was casa refarred to medical 26. Piace of Death (Check only one) axaminer' Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other Medical Certification: To 1 Yas Nursing Homa 5 Residence 6 Othar (Specify) 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 27 Menper of Death 28d. Describe how injury occurred 28b. Tima of Natural 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Pay, Year) 32. Registrar's Signeture State 2000 Registrar **DHMH 16 Rev 6/95**

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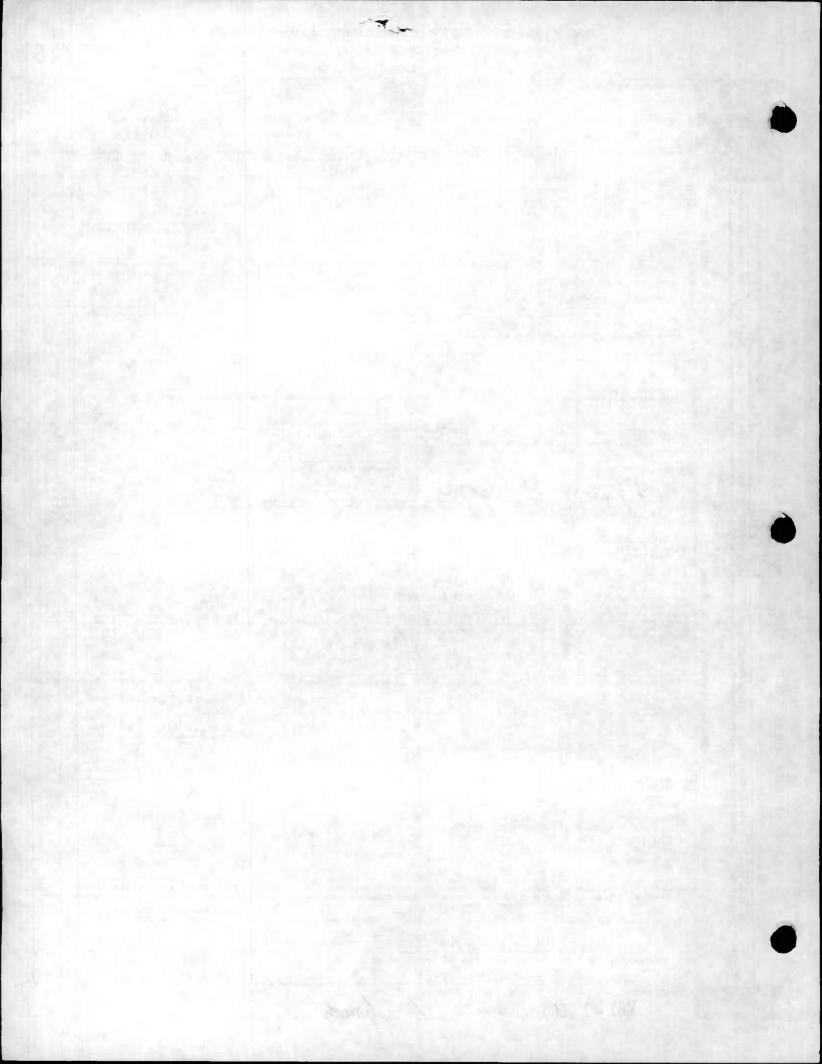
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Top State Observed Observ	r 21	.6-20-8709			Mo		If Under 24 Hr.	Dete of Di	adds.	9. Birthplac	(State or Forei	
110 All gate Road 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decederd of Hispanic Origin? (Specity Yea or Pro- 14 Page 2 Min No Specity 14 Page 2 Min No Specity 14 Page 2 Min No Specity 15. Decederts Education (Specity original Page 2 Min No Specity 16 Page 1 Min North Marital Status 16 Page 1 Page 2 Min No Specity 17 Page 2 Min No Specity 18 Page 1 Page 2 Min No Specity 19 Page 1 Page 2 Min No Specity 19 Page 2 Min No Specity 19 Page 1 Page 2 Min No Specity 19				10c. City, Tow	n or Locatio	n				100	I. Inside City Limi	
110 Allgate Road 11. Marital Status 12. Marital Chausting Marital 12. Marital Chausting Marital 12. Marital Chausting Marital 13. Marital Status 14. Marital Status 15. Marital Chausting Marital 16. Marital Chausting Marit	Ma Ma		more		Owin	gs Mil	1s				1 ☐ Yes 2 🔼 N	
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3 Suicide 4 Homicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only 20a. Certifier (Check only 20a. Certifier (Chec		Natural 5 ☐ Pending ☐ Accident investigation	on	Year) 28b. 1	njury			28d. Describe				
29a. Certifier (Check only Check only 20 Medical Examiner: On the best of my knowledga, death occurred at the tima, date and place, and due to the cause(s) and manner as 20 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due	Sertific 3	dotormino	286. Place of Injur	ry - At home, fe (Specify)	rm, street, f	actory, office		281. Location City or To	(Street and Numb wn, Stata)	oer or Rurel F	Route Number,	
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29b. Signature and little discertifier 29c. License number 29d. Date signed (Month		Signature and title dispertifier				29c. Licens	e number		29d. Date signe	d (Month, Da	y, Year)	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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/Medica		1							May	30, 2000 5:30		30 A.M
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al Directo	7	100. Street and Number 7001 North Charles Street					101. Zlp Code 21204			10g. Citizen of W United St		America
by Funeral Director		. Meritel Stetus 1 Navar Marr 3 Widowed	ried 2 Merried	H Voc Give			.S. 13. Was Decedent of Hispenic Origin? (S tf Yes, specify Cuben, Mexican, Puerl 1 ☑ Yes 2 ☐ No Specify:				- American In k, White, etc. White	
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To Be	F	miliano D		51/		Date		Angela Po				
ä	19e. Informent's Neme/Relationship (Type, Print) Dr. Rolando G. Vieta (Nephew) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State 3825 Beatty Road Monkton, Maryland 21111										State, Zip Cod	e)
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8008	2	1. Signatura of Fi	hen	ensee Jeffre	y L. Gai	r 22.1	Nama and Add	ress of Fecility Rue	ck Towson 1 50 York Rd			
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State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death 3. Tima of Death 2. Date of Death Month 2000 Year **Physician** 27 1:30 A /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLLINS AVE BALTIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number 318-88-373 7. Age (In yrs. last birthdey) **Funeral** Days Hours Months Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County City, Town or Location r than "natural", or items 23s or 28s-f shore the Medical Examiner must be notified at Itimore 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1229 death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Biack, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other then "natural", or then any Injury or other traumatic event, the Medical Emmand. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 21215-0020 1 ☐ Yes 2 D No Specify by Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry condary (0-12) Coilege (1-4or 5+) 18 Mother's Name (First, Middle, Maiden Surneme) Baltimore, Maryland Father's Name (First, Middle, Last) Paurice Freem Informent's Name/Relationship (Type, Print) 20b. Piace of Disposition (Neme of cemetery, cremetory of other p 20c. Location - City or Town, State 20a. Method of Disposition Method or Ursposinion.

1 Buriat 2 Operation 3 R

4 Donetion 5 Other (Specify) Mineral Service Licenses the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sent feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) Sunshot Wounds /Medical Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the Due to (or as a consequence of) signed by the attending p Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown λq 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Medicai Certification: To Be Completed this certificate has or Attending Physician; 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 X Other (Specify SCENE Y☐ Yes 2☐ No funeral 28e. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Tima of injury 28c. tnjury at Work? 28d. Describe how injury occurred After s after des. al Director: Afte 5 Pending investigation 1 Natural iect shot 1 Yes 2 No 130 A M 2 Accident 5-27-00 6 Could not be Location (Street end Number or Rurel Route Number City or Town, Stete) 230 5. Collins St 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Sheey To the Hospital of within 24 hours at To the Funeral D Bultimore, Mel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end manner as stated.

**Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chute no O.C.M.E MAY 27,2000 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ite mo

Registrar

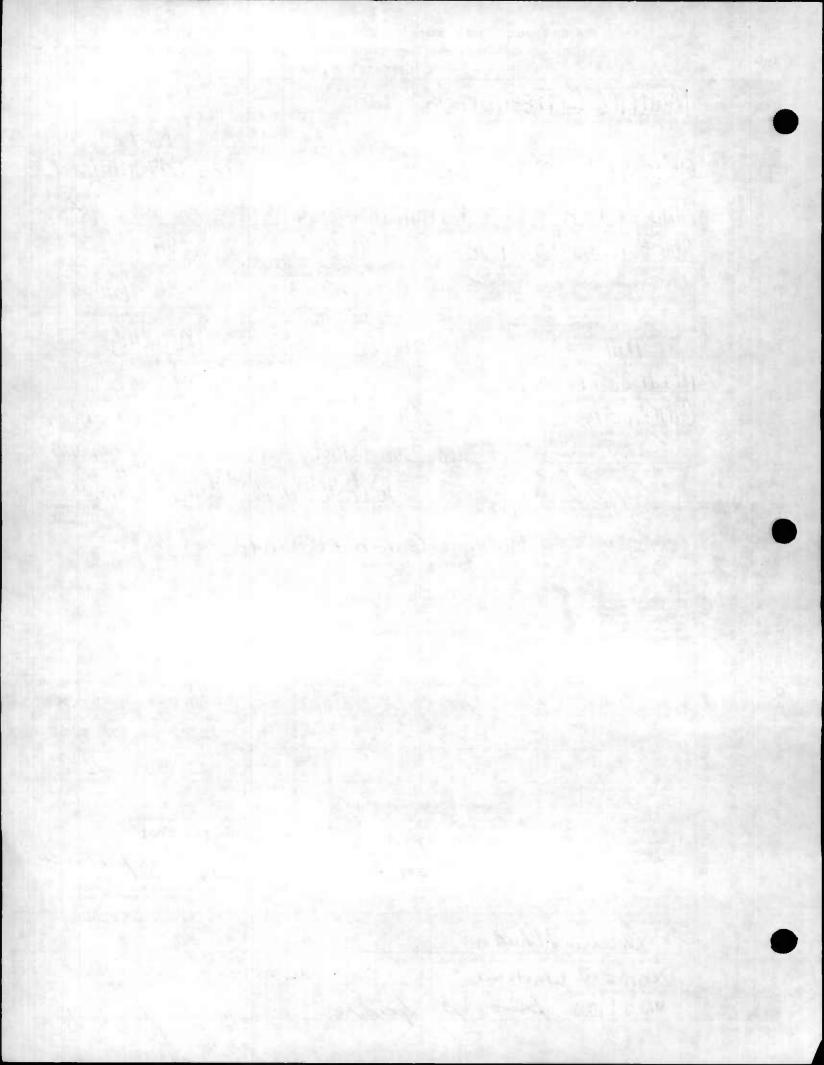
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31. Date filed (Month, Day, Year)

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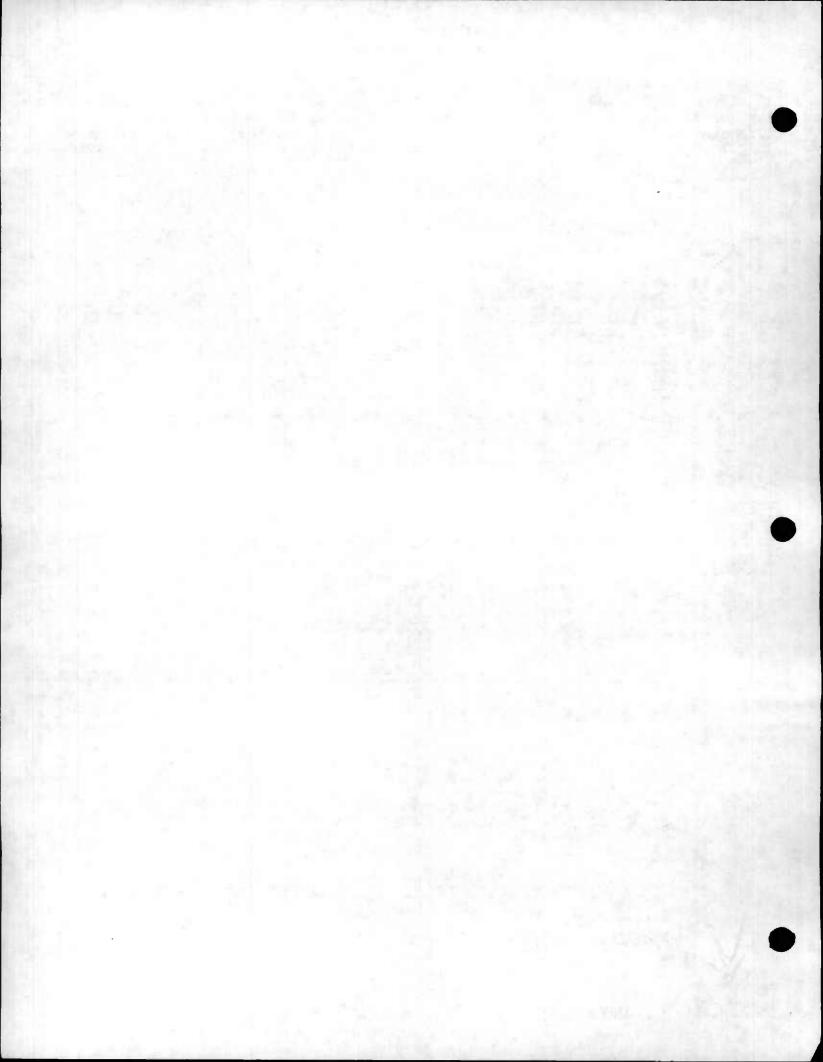
32. Registrar's Signature



Baltimor
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Baltimore, permit. Pages 1 el Department of Hea Important: if Nem 3 any injury or othe once.		1 Iz Buriel 2 Cremation 3 Hemovel from State					CEMETER Name and Addr	y ress of Fa	cility	6-06-00	BRUNSWIC	CK COW	
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Physician /Medical Examiner		Immediate Ceuse (F disease or condition resulting in death)			astat		Breast 1						Onset and Death
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To the Hospital or within 24 hours after the Funeral Director completely filled in	Medical Cer												
To the within complex	Me	29b. Signatura and ti	the of certifier fuz Li	Medical	Resid	lent	RES	nse numb	000)	29d. Date signs	_	Day, Year)
1/K	7	30. Nema and address Arthu 31. Dete filed (Month	ur Li	, Sinai	1 1	spita	Print) Ba	(+1m	ore,	Mary	and		
Registr	ar	W	W 3 1 20	00 /	perma	19	Spor	K2			76		,00

ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month Evelyn Glock 16:10 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A Hours Min. 8. Data of Birth (Month, Day, Year) If Undar 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) Months Days 1□M 20F 65 Yrs 213-32-3138 June 30, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Baltimore Co. Nottingham 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 1 Rosecrans Place 21236 United States 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 2 0 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teller 12 yrs. Banking 18. Mothar's Neme (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) Henry John Berg Margaret Rummel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2822 Glendale Avenue <u>Mrs. Judith A. Hallinger/Daughter</u> Baltimore, Maryland 21234 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/31/2000 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensae Michael E. Canapp 22. Nama and Address of Fecility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 week disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whknown 1 pertension 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? completion of causa of death? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medicel exeminer? 26. Place of Death (Check only one)

Physician /Medical Examiner

and

physician

certificata has

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

54

terns 23s or 25s-f

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permit. Pages 1 and 2 should be lited within 72 i Department of Health and Mertal Hygens. Important: If hem 27 is merked other than "natu any Injury or other traumatic award the and

hours after

Maryland 21215-0020

Baltimore,

the Medical Examiner must be notified at

Directo

Funeral

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Completed

Be

Examiner bunial-transit the for use apital or Attending Physician: Thours after death.
Ineral Director: After this certification filled in by the funeral director, pa edical Certification: To

Be

27. Manner of Death

Completed by Physician/Medical

To the Hospital o within 24 hours af To the Funeral Di completely filled is

State

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be determined

MD

29c. License number P12558

28c. Injury at Work?

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 28,2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 5601 Donabedian

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

Loch Raven

Blvo

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

Registrar

31. Date filed (Month, Day, Year) MAY 3 1

1 Yes 2 No

1 Natural

2 Accident

3 ☐ Suicida

29e. Certifier (Check only one)

4 Homicide

32. Registrar's Signature Docks

2 ER/Outpatient 3 DOA

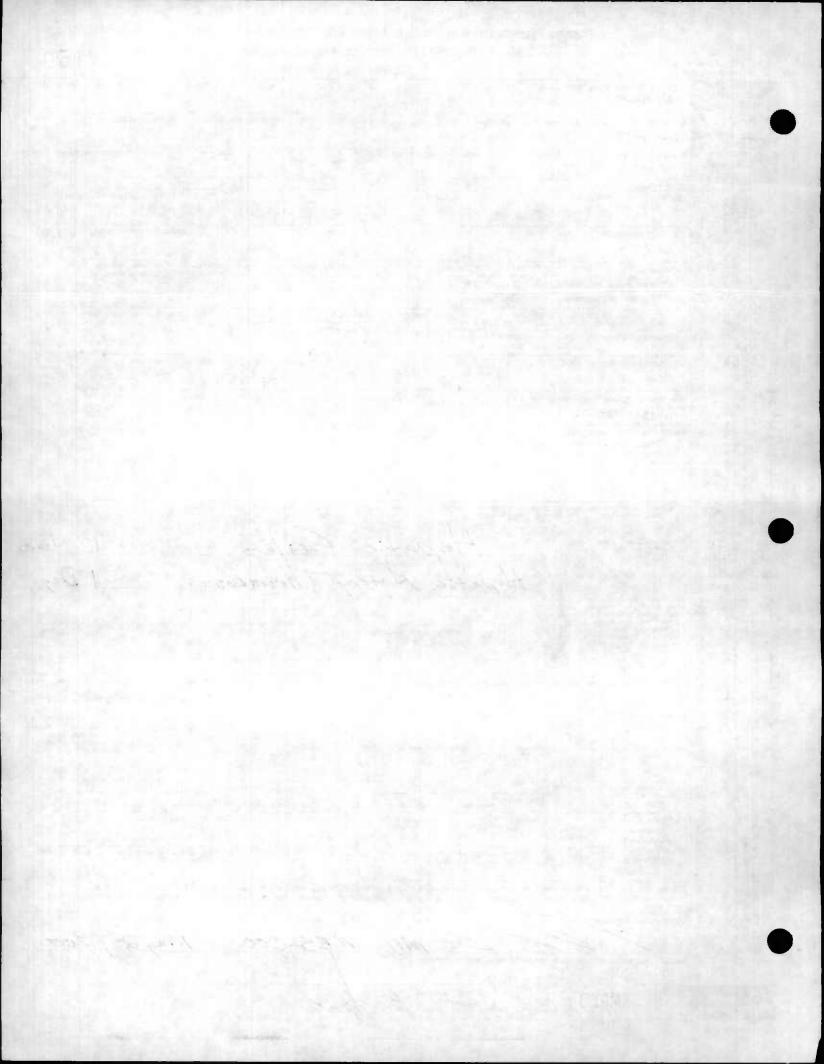
28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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State of Maryland / Department of Health and Mental Hygiene

	a dissay			iai yiaila i	Certific	ate of		R	eg. No.		1150	
	Physician	Decedent's Nama (First, Mide Edmond Grace	-	2. Data of Deal Month May	3 Day 2000	Yaar	3. Tima of De 6:12 at					
	/Medical Examiner	4a Facility Nama (If not instituti	4b. City, Town, or Lo	ocation of Death	4c. County	of Death						
		The Johns Hopkin	-				Baltimore		N/A			
Funeral Director		5. Social Security Number 150–16–4615	6. Sax 7. / 11☑13M 2□ F	Age (In yrs. last bii 72	Yrs. If Un Monti	hs Days	If Undar 24 Hrs. Hours Min,	8. Data of Birth (Month, Day Sept. 12		9. Birthpl Count NJ	ace (State or Fi ry)	oreign
	pu s	Usual Rasidence of Decedant 10a. Stata 10b. Count	v	10c. City, Tow	m or Location					10	d. Inside City L	Limits
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	ier death with the Manyler Herne 23e or 28e-f show tree man be notified at Tuner real Director	10e. Street and Number 2551 Bachmantown	Road		10f.	Zip Code 17572			0g. Citlzan of W USA	hat Country?		
0020 ours efter dea reit, or Nerma	of, or	11. Marital Status 1 □ Nevar Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	Armed Force	Vas Decedent Evar In U,S. rmed Forces? ☐ Yas 2 ☐ No 45-47 Yes, Give 'aer or Detes: 13. Was Decede if Yas, speci			lispanic Origin? (Sp an, Maxican, Puarto Specify:	o- 14. Raca - American Indian, Black, Whita, atc. Specify: White				
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es 1 and of Health	12 F	19a. Informant's Name/Reletior Claire Grace /					and Number or Aur Road, Ronk			Stete, Zip	Coda)	
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Balti	pemit. Peg Department Important: It eny Injury o DICE.	21. Signature of Funeral Service VICTOR P.	ess of Facility Ch	arles L.				nc.				
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	Physician /Medical Examiner	shock, or heart failure. List Immediate Cause (Finel disease or condition resulting in death)	st only ona causa on aach	Hepa	atic	. 4	-arlun	e			Intervel Between Onsat and Das	ith rays
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Division	tal or Attending P is after death. In Director: After t ed in by the funer: Certification:	3 Suicide 6 □ Could	d not be 28a. Place of	Injury - At homa, fa etc. (Specify)		M 1 ☐ Yas 2 ☐ No at, factory, offica 28f. Location (Street and Num. City or Town, Stata)					l Routa Numbe	r.
	Hospi 24 hou Funer tely fill		ing Physician: To the besit Examiner: On the basis and mannar	of axamination ar								
	within To the comple	29b. Signature and title of cadili-				29c. Licans	sa number	2	9d. Date signad	(Month, i	Day, Year)	
	- 3 - 0	1//	5-000	3	May &	25	200	>				
		30. Nama and addrass of person	n who completed causa o	f daeth (Itam 23a)	(Type, Print)	1-2			and o	1		
		Gene Greenless MD	600 N. Wolfe	Street Ba	ltimore.	MD 21	287					
	State Registrar	31. Data filed (Month, Day, Yea		strar's Signature	B,	Span	5					



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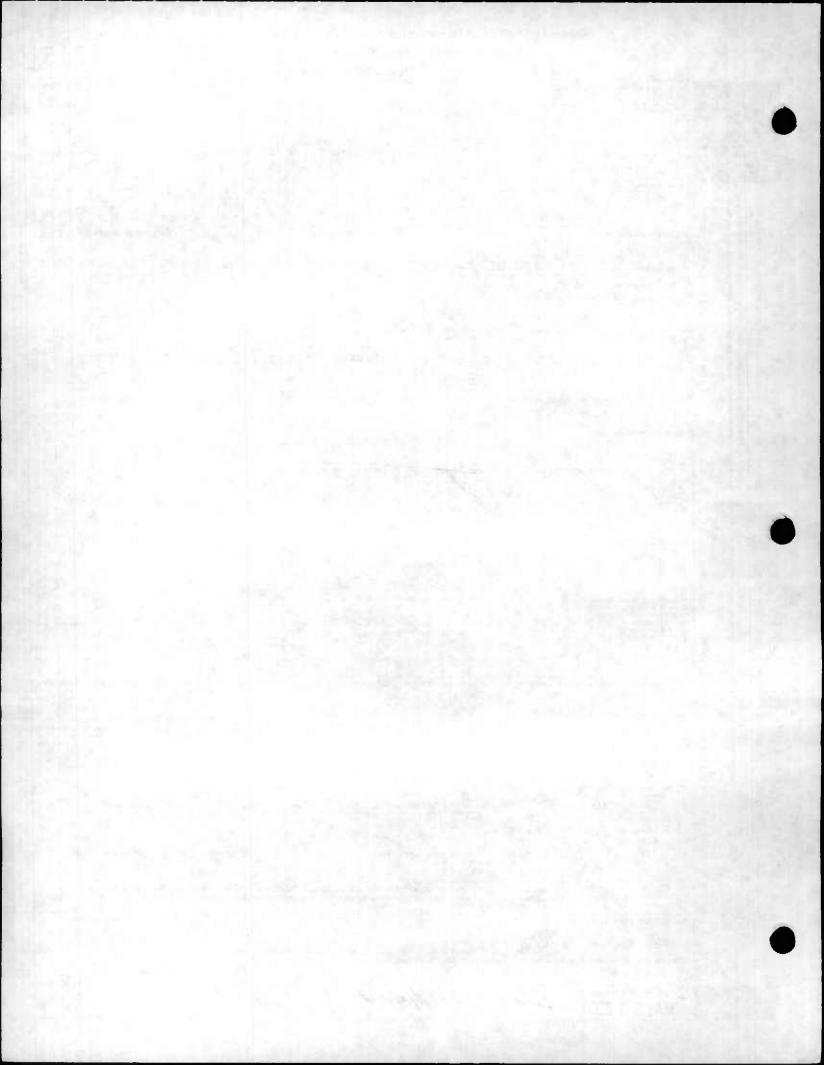
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** FANNIE ROSE **GOLDBERG** 2000 MAY 12:45AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT & NURSING HOME BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country)
 MD • 7. Aga (In yrs. last birthday) **Funeral** Hours Days Months 1□M XXF 91 Yrs Director 213-32-2989 Usual Rasidance of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow other traumatic event, the Medical Examiner must be notified at MD N/A BALTIMORE 1 Yas 2 No Funeral Director or items 23a or 28a-f 10e Street and Number 10f Zip Coda 10g. Citizen of What Country? 3020 FALLSTAFF ROAD 21209 USA 12. Was Dacadant Evar in U,S. Armed Forcas? Was Decadent of Hispanic Origin? (Spacify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. pernit. Pages 1 and 2 should be filed within 72 hours after Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or has any Injury or other traumation. 1 ☐ Yas 2 ☐ No If Yas, Giva X 1 Navar Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 No Specify ð Specify: WHITE 3⊈ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working iffe. DO NOT usa retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) NATHAN CAPLAN **ESTHER** SKLAR 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) DEBRA LYNN ZYLBERBERG/DAUGHTER ASPEN GLEN COURT OWINGS MILLS MD. 21117 altimore, 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data comatary, cramatory or other place)
BOBROISKER BENEFICIAL CIR5/28/00 t Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE, MD. LODGE 21. Signatura of Funarai Sarvice License 22 Nama and Addrass of Facility SOL LEVINSON & BROS. INC. au REISTERSTOWN ROAD PIKESVILLE, MD 21208
moda of dying, such as cardiac or raspiratory arrest.

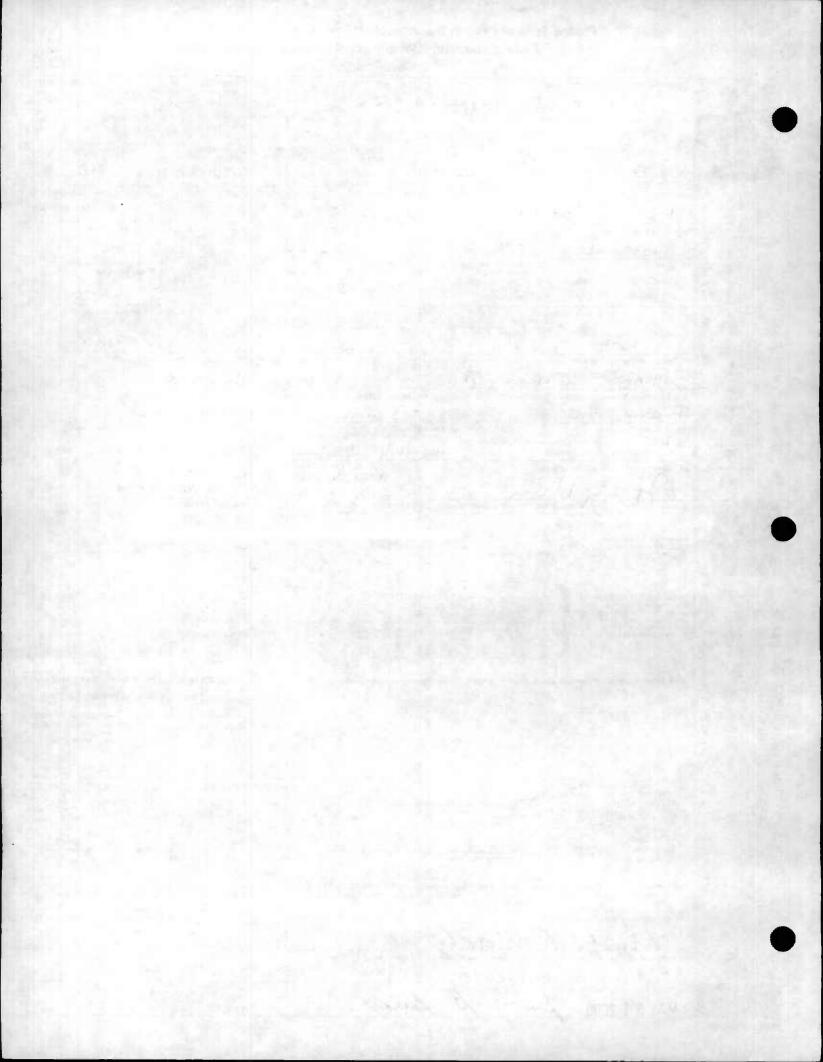
Approximate 23a. Part1. Enter the disease, or complications the shock, or heart tailure. List only one cause or the and the death. Do not en Intarval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Dua to (or as a consaquance of): Examiner Des tension The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated evants rasulting in daath) Last Qualto for as a consequence of) cordio vasculos Artenoschotic Box 68760 physician Physician/Medicai Dua to (or as a consequence of) for use Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. be deteched 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown ð 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed this certificate has 2 KINO 1 Yas 1 Yes 2 No or Attending Physician: 25. Was case rafarrad to medical axaminer? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Vursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 1 Yas 2 000 funeral 27. Mannar of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? After Division 1 Natural 5 Pending invastigation s after death. 1 Yas 2 No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) filled in by 4 | Homicida To the Hospital o within 24 hours at To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier completely (Check only 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Ligensa number Louis 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) OvereTree Rd # 300 1838 HD Willer 31. Data filed (Month, Day, Year) 32. Registrar's agnatura State

DHMH 16 Ray 6/95

Registrar

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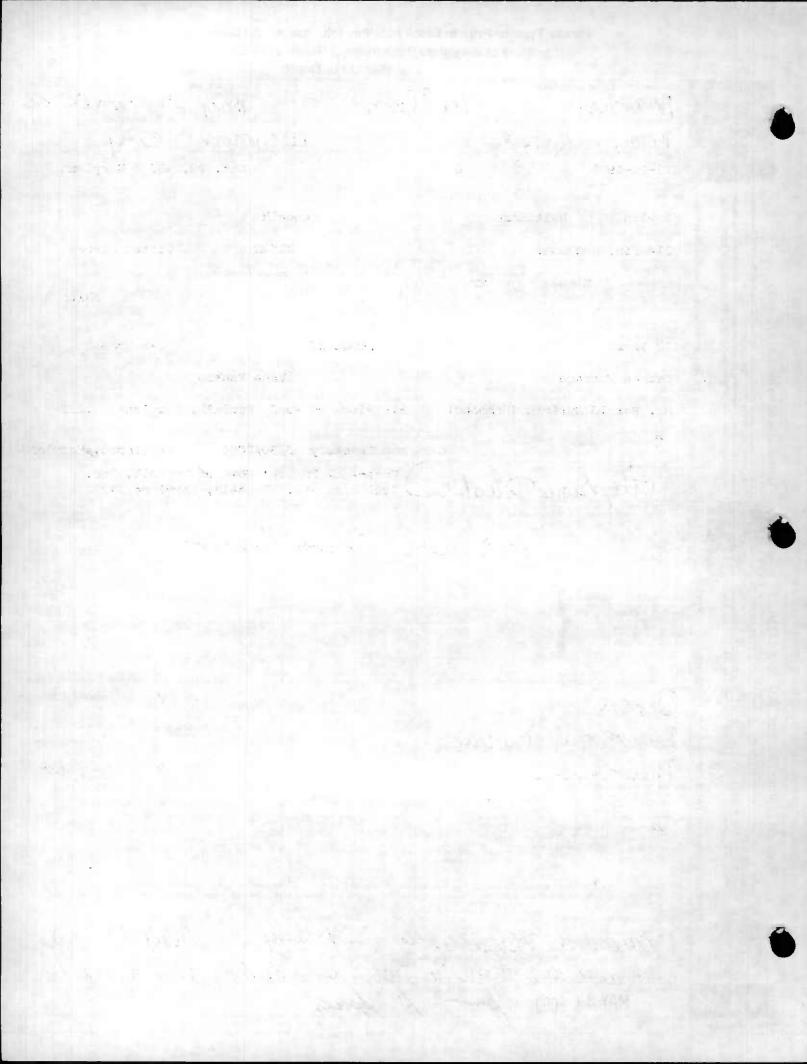
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 05:22 2000 /Medical 4b. City, Town, or Location of Death Fecility Name (If no institution, give street end number) 4c. County of Deeth 4a Examiner Spital 5. Sociel Security Number If Under 1 Months Bethplace (State or Foreign 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day **Funeral** 1 M 204 20,1935 Vrs 213-30-0901 Director 64 Oct. Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples traumatic event, the Medical Examples traumatic event, the Medical 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 1 21222 314 Pinewood Road United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 72 hours efter 1 Yes 2000 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 72.1 Department of Health and Mental hygiene. Important: if itam 27 is marked other than "natu any hojury or other traumatic event, the Manical pince. 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Years Housewife Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Sumeme) Be Edna Rankin George Mugrage 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Harold Huffman (Husband) 314 Pinewood Road Dundalk, Maryland 21222 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 5/30/2000 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner sician and bunal-transit Sequentially list conditions, if ony, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as e consequence of): certificate be execu P.O. Box 68760, attending physician Physician/Medical the Dua to (or as a consaguance of): USB 88 signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24e. Wes en autopsy peeu Fallene hes 1 Yes 20190 1 ☐ Yes 2 10 Division of Vital lumerio or Attending Physician: efter death. Director: After this certifice funerel director, Be 25. Was case rafarred to medical examiner? 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 Dopatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Anaturei 5 Pending Injury 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, streat, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 12 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and mennar as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Data signad (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number

of deeth (Item 23e) (Type, Print)

32. Registrats Signatura

State Registrar nd address of person

1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day Yea **Physician** 0130 AM Margaret Beatrice Hooks MAY 2000 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner SAINT AGNES HOSPITAL N/A BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. May 30, 1923 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign N. Carolina 7. Age (In yrs. lest birthday) **Funeral** Months 1 M 2 XE 214-20-1227 76 Yrs. Director Usual Residence of Decedent the Marylend 10a, State 10b County 10c. City. Town or Location 10d. inside City Limits r than "natural", or itema 23a or 28a-f ehov the Medical Examiner must be notfilled at 1 ☐ Yes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Heelth and Mentel thyglene.
Important: If them 27 is marked other than any fujury or other treumed.

BODGS. 21229 346 Gwynn Avenue Funeral t2. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No tf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black à 3 X Widowed 4 Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Medical Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Samuel Jeffries Cora Keith 19e. Informant's Name/Relationship (Type, Print) (Sons) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Glenn Hooks & Clifford Hooks 346 Gwynn Avenue Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/02/00 Crownsville, Maryland Maryland Veterans Cem 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215 The the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart tailure. Inst only one cause on each line. 23a. Partt. Approximate Intervet Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Gram negative organisms Examiner Due to (or as a consequence of): Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 Yes Vital MARGARE 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 [Inpatient 2 2 ER/Outpatient 3 DOA to 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division t Matural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 24 54 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balsh: Year) State 2000

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month DSALIE 0-05 Am 2000 MAL 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death SAMARITAN HOSPITAL 6000 N/A BALTIMORE if Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec. 13, 1922 9. Birthplaca (Stata or Foreign Country) West Virginia 5. Social Security Number 7. Aga (In yrs. last birthday) Hours Months 1 ☐ M 2 🖾 F 232-32-8636 Yrs. Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 N Yas 2 No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code t0g. Citizen of What Country? 2605 Orleans Street 21224 United States 12. Wes Decedant Evar in U,S. Armed Forcas? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify. 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Eiamentary/Secondary (0-12) 11 Years Coilega (1-4or 5+) Housewife Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Lee Phillips Grace M. Smith 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) David Stevens (Son) 1785 Brookview Road Dundalk, Maryland 21222 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data to Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Moreland Mem. 5/31/2000 Baltimore, Maryland Cem. unaral Sarvice Licensee 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Entar the isaasa, or complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or head, silure. List only one ceuse on each line. CHRONIC DASTRUCTUS PULMORARY DISPASE Immediata Ceuse (Final disaasa or condition rasulting in daath) Dua to (or as a consequence of) Sequantially list conditions, if any, laading to immadiate ceusa. Enter Underlying Cause (Diseese or injury that initiated avants rasulting in daath) Last Due to (or es a consequence of) Dua to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 2 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of ceusa of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was cese refarred to medicel axaminar? 26. Place of Death (Check only one)

Physician /Medical Examiner

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Physician

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permit. Paiges 1 and 2 should be filed within 72 hours attar. Department of health and Mental Hygiane. Important if flem 27 is merked other than "natural, or its may injury or other traumatic event, the Medical Examina

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Box 68760.

Division of Vital Records, P.O.

Examiner Physician/Medicai funeral

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or Attending Physician: To the Hospital within 24 hours a To the Funeral Completely filled

After t

State Registrar

Certification: after death.

I Director: After the full of the full o edicai

29b. Signatura and titia of certifiar

5 Panding invastigation

6 Could not be determined

1 Yas 2 No

27. Mannar of Death

1 Natural

2 Accidant

3 Suicida

29e. Certifier (Check only one)

4 Homicide

MO

28a. Data of Injury (Month, Day Year)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated. 29c. Licansa numbar

13457

28c. Injury at Work?

1 Yas 2 No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

28d. Dascribe how injury occurred

29d. Date signed (Month, Day, Year)

3601 LOCH RAVEN

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Name and address of person who domplated cause of death (Itam 23a) (Type, Print)

POSEMARIE LAMPERIAD-MALAS 106000 SALVARITAN HOSPITAL PLUD. BALT 21239

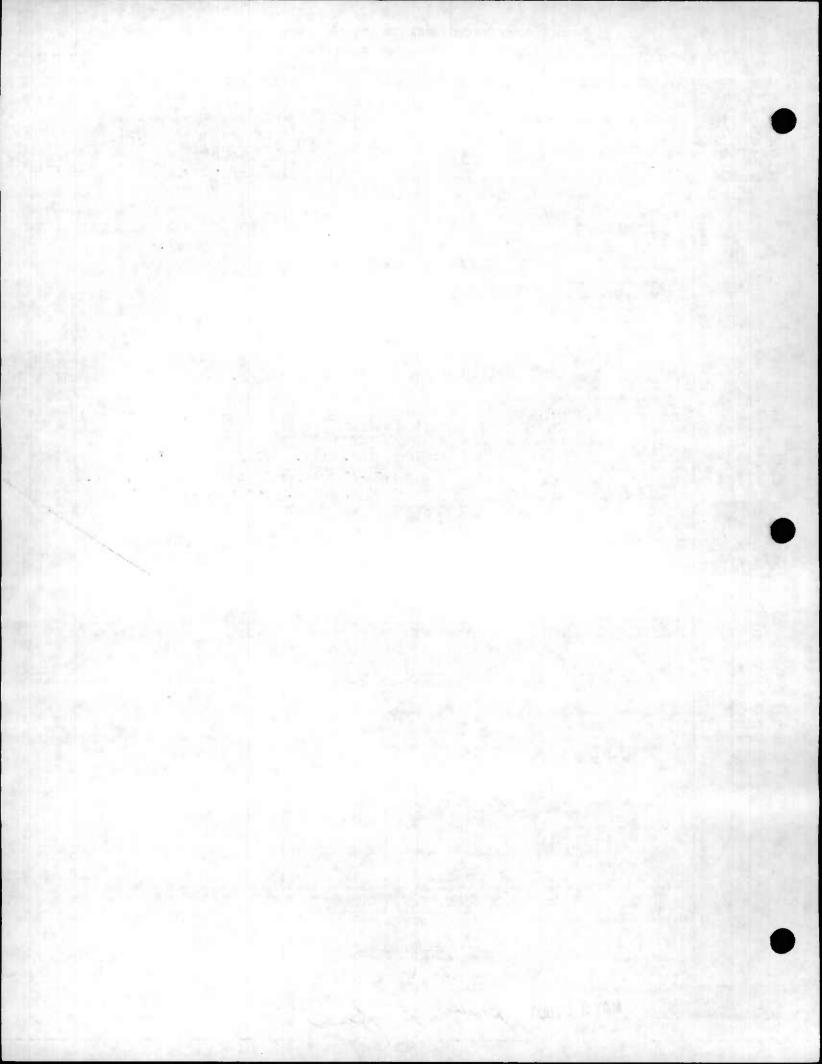
31. Data filed (Month, Day, Year)

32. Registrer's Signetura

Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 8:50AN 26,2000 Robert. Hall 194 H . /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore tranklin Square osedale Hospital Center If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. lest birthday) 5. Social Security Number If Under 6 Sex Birthplece (State or Foreign Country) **Funeral** Months Deys MOM 2DF Director 216-14-7945 MD Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show mant be notified at 1 Q Yas 2 □ No Director MD Baltimore 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 6 2123 Homewood Avenue 21218 234 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) items! 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, Bleck, Whita, etc. Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene. Int: If flem 27 te marked other than "natural", or its 1 ☐ Never Merried 2 ☐ Merried 1 ☑ Yes 2 ☐ No If Yes, Giva altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify à 3 2 Widowed 4 ☐ Divorced Yeer or Detes: Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) High Sch. Grad NA Postal Service U.S. Postal Service 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be Bernard Hall Annie Gent permit. Pages 1 and 2 shoul Department of Health and Me Important: If Item 27 Is mark eny Injury or other traumationa. 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Constance Hall 2123 Homewood Avenue Baltimore, MD 21218 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete M.D. 20a. Method of Disposition Dete 1 Buriei 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cem. 06-01-2000 Owings Mills 22. Name and Address of Facility Baltimore, Maryland 21202 tura of Funeral Service License WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onset end Death **Physician** /Medical immediate Cause (Final disease or condition resulting in deeth) neumonia Examine Physician/Medical Examiner erebrovascular 10 Years The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760, the Dua to (or es e consequenca of): USB 88 P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Were autopsy findings available prior to completion of causa of death? 24e. Was en eutopsy performed? Be Completed page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No edical Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Death 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 5 Pending investigation after death.

Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funerel Di completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and fitte of certifie 29c. License number Luzza, MD pleted cause of death (item 23a) (Type, Print)

Square Drive Baltimore, MD 21237

9000 Franklin

32. Registrar's Signeture

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31. Data filed (Month

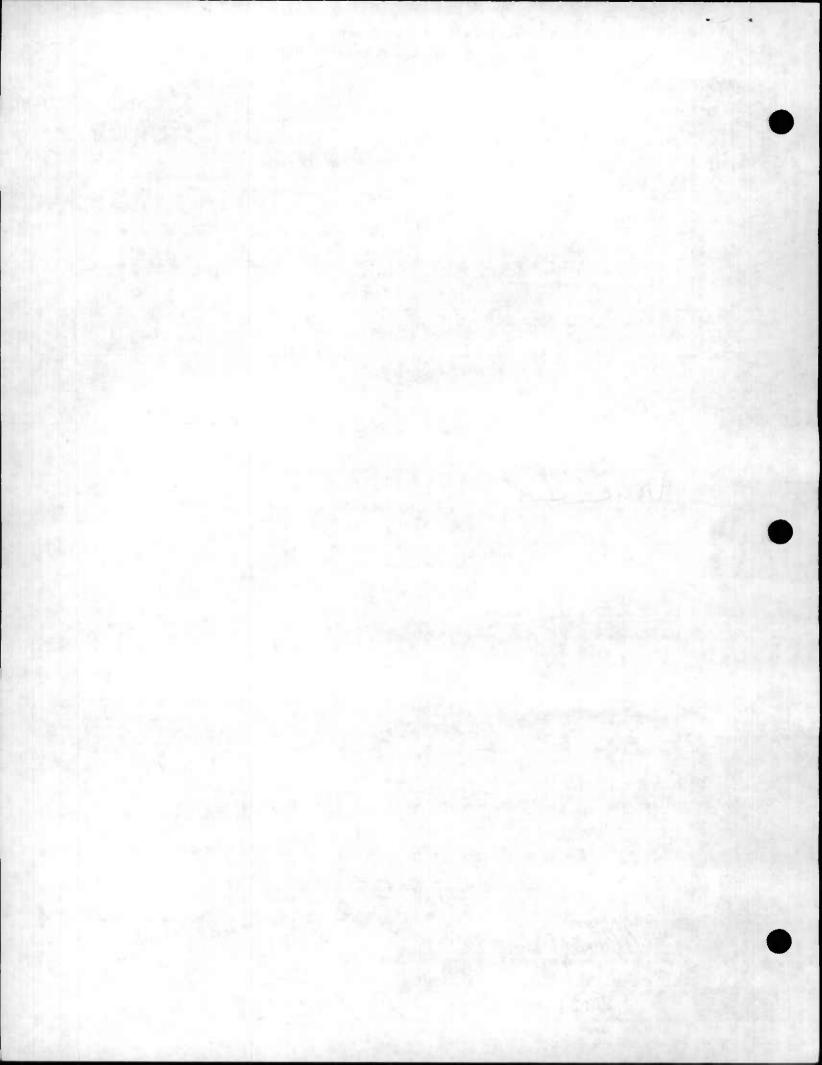
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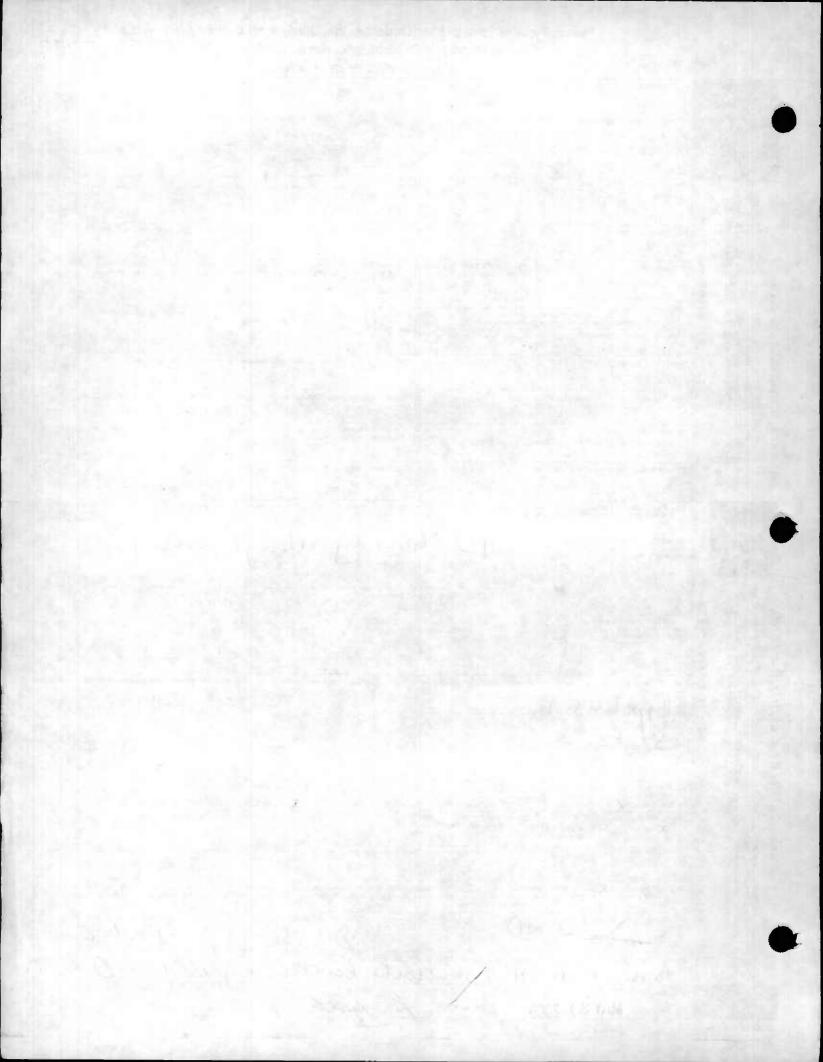
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	/Medical Examiner		Location of Deeth	4c. County of Death	. J. L. Opm							
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	Funeral Director	5. Social Security Number 6. Sex 1 Months 1 Mont		9. Birth	olece (Stete or Foreign ntry) NC							
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a di	ect moth	10e. Street and Number 10f. Zip Code	100.	10g. Citizen of What Country?								
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		21. Signature of Funeral Service Licensee 22. Name and Address of Facility B										
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DIVISION To the Hospital or Attending	within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pled control of the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pled control of the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pled control of the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pled control of the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pled control of the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pled control of the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pled control of the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pled control of the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pled control of the basis of exeminetion end/or investigation, in my opinion, deeth occurred et end										
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ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3 Time of Death Year Month **Physician** LEONARD RAY HENDERSON IX 0219 May 25 Zero /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Death Examiner MEDICAL SYSTEMS KATIMORE UNIVERSITY OF MARYLAND BALTIMORE If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 31 212-92-5764 Yrs Director 02/01/69 Maryland Usual Rasidanca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ahor treumatic event, the Medical Examinar must be nouthed at 1 Yas 2000 Director Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21227 United States 3407 Benson Avenue Funeral 14. Race - American Indian, Black, Whita, etc. 12. Wes Decedant Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Peges 1 and 2 should be filed within 72 hours after of health and Mertel Hyglene.
Intel filem 27 is marked other than "natural", or fles
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Intelligent traumatic event, the Medical Energing. 1 Yas 2 No If Yas, Giva Yaar or Dates: NT Never Married 2 Married 21215-0020 Specify: White 1 ☐ Yas 2 ☐ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) General Contractor Home Improvements Baltimore, Maryland 18. Mother's Name (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Be Leonard Ray Henderson III Carol Estelle Vetters 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Leonard Ray Henderson III (Father) 3407 Benson Avenue Baltimore, MD 21227 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If the any injury or ot 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 5/29/00 Catonsville, MD Metro Crematory, Inc. 21. Signature of Funaral Sarvice Liberature 22 Nama and Addrass of Facility Ambrose Funeral Home of Lansdowne C 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Pert1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Fine) FULMINANT HEPATITIS disease or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Causa (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medicai Dua to (or as a consequence of): US0 08 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yee 2 1 No 3 ☐ Probably 4 ☐ Unknown HEPATITIS C Records, þ 8 24b. Were autopsy findings eveilable prior to completion of causa of death? Completed 24a. Was an autopsy page 2 hes 1 Yes 2 No 1 ☐ Yas 2 W No certificate Division of Vital funeral director. 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending invastigation 1 TYas 2 No within 24 hours after death. To the Funeral Director: Al 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicida Hospital 29a. Certifiar 128 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

State

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Registrar

29b. Signatura and titla of certifiar

DEPT MD 32 Registrar's Signature

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

3 1 2000

am

DHMH 16 Rev 6/95

2-6

29c. License number

SURGERY

(RESIDENT)

#12458

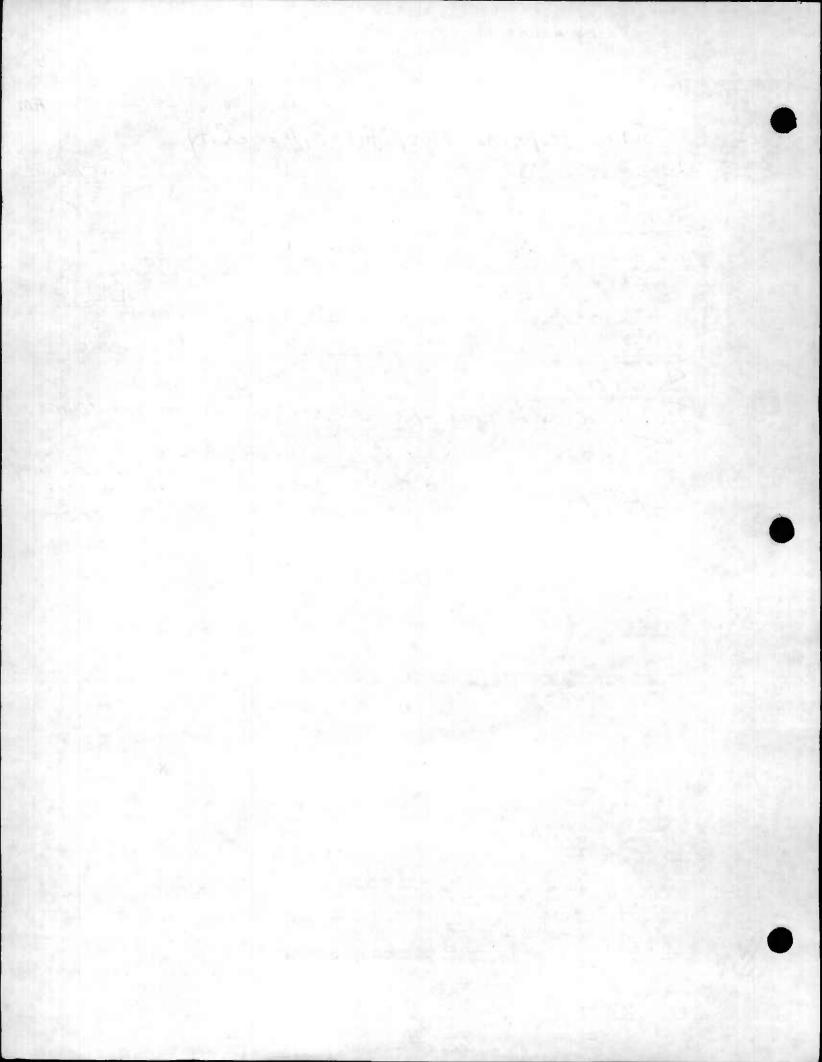
29d. Data signed (Month, Day, Year)

UNIV. of Mary lang

2000

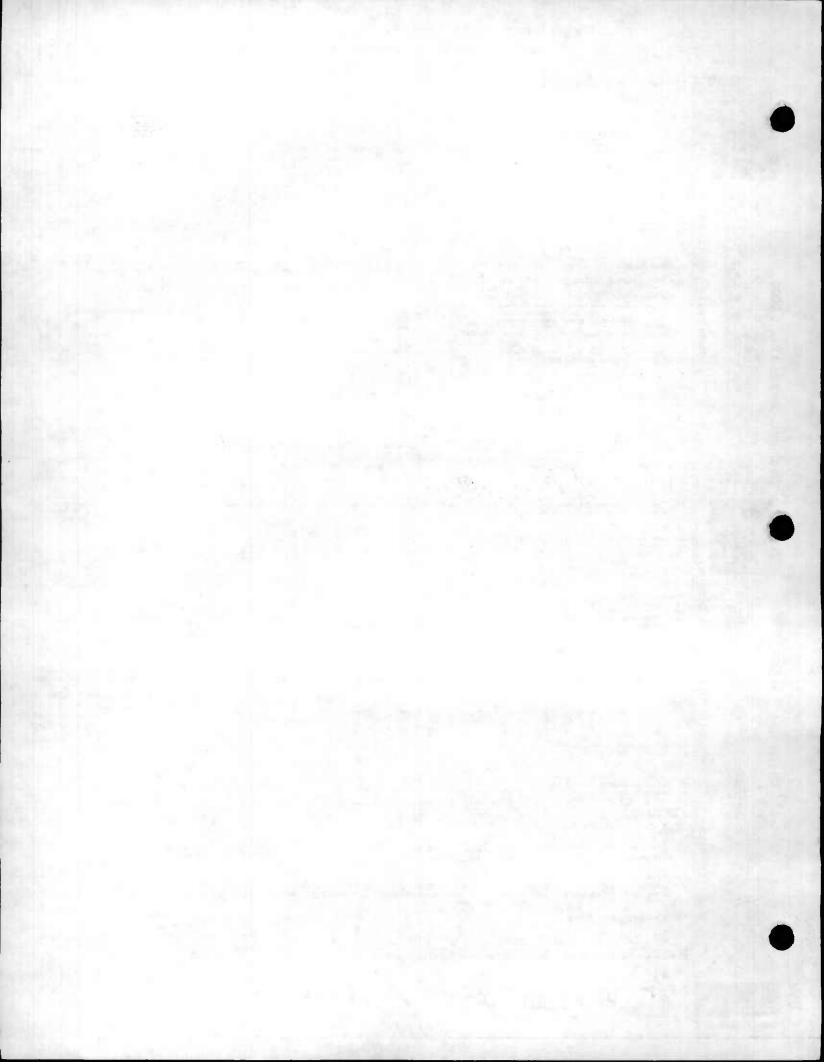
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 0 95 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 1 Under 1 Year 11 Under 24 Hrs. 8. Date of Birth Month, Day Year (Month, Day Year) 9. Birthplace (Steta of Death Month, Day Year) 1 Months Day Hours Min.
4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4d. County of Death 4c. County of Death 4d. County of Death
5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Under 1 Year Under 24 Hrs. 8. Date of Birth 9. Birthplace (Steta of Birth Day New Month Day Year) 9. Birthplace (Steta of Birth Day Year) 9. Birthplace (Steta of
246-30-4332 1UM 22 8/ Yrs.
Usual Residence of Decedent
10e. State / 10b. County 10c. City, Town or Location 10d. Inside C
Md Baltimore 10090s
10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10f. Zip Code 10g. Citizen of What Country? 11g. Was Decedent Ever in U.S. 11g. Was D
3 □Widowed 4 □ Divorced Year or Dates: 1 □ Yes 2 □ No Specify: Specify: Specify:
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO_NOT use retired) 16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) To menally Do mestic
17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme)
Sam Fenner Monor McDaniel
19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
20e Method of Disposition V 20b. Place of Disposition (Name of Disposition - City or Town, State
1 Provided 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Provided A Moderation 1 State (Specify)
21. Signature of Fineral School Leansee 22. Name and Addrass of Facility 16.39 W. Market
Millen Meles Chapel Bablo Ma
23a Part I Enter in Sease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Short failure. List only one cause on each line. Approximat
Onset and
Immediate Cause (Final disease or condition resulting in death) a. LACTIC ACIDOSIS THREE
Due to (or as a consequence of):
B. RENAL FAILURE
Sequentially list conditions, if any, leading to immediate ceuse. Enter Undertying Cause (Disease or injury C.
Cause (Disease or injury that initiated events Dua to (or as a consequence of):
Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4
1 Yes 2 No 3 Probably 4
24a. Was an autopsy performed? 24b. Were autopsy available prior completion of of death?
1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 🛱
25. Was cese referred to medical examiner?
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Pending investigation 28a. Date of Injury 28b. Time of 28c. Injury at 28c. Injury at 28c. Injury at 28d. Describe how injury occurred Work? 1 Yes 2 No 28a. Date of Injury 28b. Time of North North North Injury 28b. Time of North North Injury 28c. Injury at North North Injury 28c. Injury at North Injury North Injury 28c. Injury at North Injury 28c. Injury at North Injury North Inju
2 Accident investigation M 1 Yes 2 No 3 Suicide Su
29a. Certifier 29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(and manner stated).
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
EL- CAM, NEDICAL DOCTOR RES-000 MAY 24, 2000
30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) ERIC CHOW,
JOHNS HOPKINS HOSPITHL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 22287
te 31. Date filed (Month, Dey, Year) 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

I	AMEND I	TEM: #1	OF G786	State of 8 - 25 - 0 (Marylan WR.	d / Depa <i>Cer</i>	irtment of F tificate of	lealth and Death	d Mental Hy	/giene Reg. No.	00	17161.
	Physician		1. Decedent's Neme (First, Middle, Last) Mary Frances Hayden								2000	3. Time of Deeth
	/Medical	-	(If not institution, give		harl			4h City Town	or Location of Dee	29 th 140 Co	ounty of Death	3:30 A.M.
(8)	Examiner		yne Ave.	Street and num	5617			Laurel	Of Education of Dog	I .	nce Geo	rge
	Funeral Director	5. Social Security 022-30-8	3741	6. Sex 1 □ M 2 ☑ F 7. Age (In yrs		last birthday) Yrs.	If Under 1 Year Months Deys		Hrs. 8. Date of B	irth Pay Year) 1942	h -	elece (Stele or Foreign echusetts
P	ð m	Usual Residence 10a. Stete	of Decedent 10b. County		10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
deep with the Maryland	28a-f ahov notified at rector	MD	Prince G	eorge	Lau				1 ☐ Yes 2 🖾 🛣			
4	or 28a-1	10e. Street and N					10f. Zip Code				of What Cour	ntry?
3	23		ayne Ave.	12. Was Deced			-207		707	U.S		
- E	or, or he manning		1 Never Merried 2 Merried 1 Yes 3 Widowed 4 Divorced Year			f	Yes Decedent of N	an, Mexican, Pu	? (Specify Yes or N uerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White	
21215-0020	ygiene. Nr. fra Medical En. Completed by	(So	15. Decedent's Ed					eation during most of	working	16b. Kind	of Business/Inc	dustry
121 iff	then the Men	Elementery/Se		College (1-4	lor 5+)		OO NOT use retire			U.S.	Governm	ent
	other vent, it	17. Father's Nem	e (First, Middle, Last)	4				18. Mother's	Neme (First, Middle	e, Maiden Su	mame)	
Maryland	Mentel H mrked ott dc ever To Be	Francis							Shannon			
ary	N pue	19a. Informent's	Neme/Reletionship (7	ype, Print)		19b. Meilin	g Address (Street	and Number of	r Rural Route Num	ber, City or To	own, Stete, Zip	Code)
	n 27 in		Hayden -	Spouse			5 Wayne	Ave.				
Baltimore,	Department of Health end Mental Hyg Important: If Item 27 Ie marked other eny Injury or other treumatic event, once. To Be C		sposition Cremetion 3 Other (Specify		0	emetery, cren timore		ton Cr.	5/30/20	00 Lau		
Bal	Depart Import eny In	KIM	uneral Service Licent	Road La	Funeral Home Laurel, MD 20707							
88760, m		Immediate Cause disease or condit resulting in death	conditions, immediate derlying or injury	a. Coltr	Due to (or	and Consequence a consequence of a conse	uence of):	1	Antii	70	iver	Approximate thereel Between Onset and Deeth
, P.O. Box 6	ed by the detects	Part If, Other sign	ificant conditions co	d	th but not resu	ulting in the ur	nderlying cause giv	ren in Pert I.		23b. Did tobacco use contribute to the cause of d		
Records,	a been a 2 should pleted				Phy :				24a. We per	s en eutopsy formed?	ev	ere eutopsy findings alleble prior to mpletion of cause death?
	pege 2	Electronic Control							10	Yes 201	¥o 10	Yes No
Vital	s certificate director, peg To Be Co	25. Was case refe	1						Death (Check only	one		
of Vita	9 0	1 Yes	No	Hospitel: 1 Inf		ER/Outpatien	3 DOA	ner: 4□ Nursin	- 4	- Contract of the Contract of	Other (Specif	y)
Division of Attending P	a star death. I Director: After the In by the funeral Certification:	1 Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending investigation		Day Year)	28b. Time of Injury		y et rk? Yes 2 ☐ No	Sea poplar			
5 6	res after rel Direc led in by	4 ☐ Homicide		28e. Plece of building	e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)					(Street and Nown, Stete)	vumber or Hurs	I Route Number,
To the Hospital	within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)	1☑ Certifying Phy 2☐ Medical Exam	sician: To the be iner: On the basi and menne	is of examinat	wledge, death ion and/or inv	estigation, in my o	pinion, deeth o	lace, end due to the occurred et the time	, date end pla	ace, and due to	the ceuse(s)
	To som	29b. Signeture en	d title of certifier	a	206	m	29c. Licens	e number	3	29d. Date s	igned (Month, - 29 -	2000
(8	MARIE	dress of person who c	100 BYN	15	7350	Print) Van	Dese	ned.	#42). (an	olmd
2	State Registrar	31. Date filed (Mo	MAY 31 2	32. Reg	pipfrar's Signar	lupa /9	Spa	4				12070)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** BEATRICE F HERSHBERGER 26,2000 194 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number, 4c. County of Death Examiner Baltimore Square Hospital Center Ser 6. Sex 1. Age (In yrs. lest birthday) Kosedale 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) April 10 1922 Birthplaca (State or Foreign Country) Maryland **Funeral** Months Days 1□M 2√F Hours Director 215-16-4792 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Director Baltimore Essex 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? "natural", or itema 23a 243 Orville Road 21221 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: à Specify. White 3 Nidowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker own home 10th pelij Department of Heelth and 2 should be file Department of Heelth and Mantel Hyg Important: If Item 27 is marked other any hijury or other treumatic encours. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Robert Walker Naomi Broombach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Norma Black / daughter 2510 Burgundy Drive Fallston MAryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Cemetery 5/30/2000 Baltimore MD. 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 23a. Part1. Enter the disease, o shock, or heart failure. List Approximate Interval Between Onset and Death polications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · Ventricular Tache mmediate Examiner Physician/Medical Examiner 5 years oro nary Sequentially list conditions, If any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760 rteriosclerosis 5 years Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? hronic Obstructive Pulmonary Disease 1 Yea 2 No 3 Probably 4 Unknown Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Be Completed Fibrasis, Cor Pylmonale completion of cause of death? 1992 2) No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 27. Manner of Death 28a. Date of tnjury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident 5 Pending investigation efter deeth. Director: Aft d in by the fur 1 Yes 2 No 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Discompletely filled in Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier \$ 29b. Signature and titla of certifie 29c. License number 29d. Date signed (Month, Day, Year) 50.

State Registrar

DHMH 16 Rev 6/95

31. Daile filed (Month, Dey, Year)
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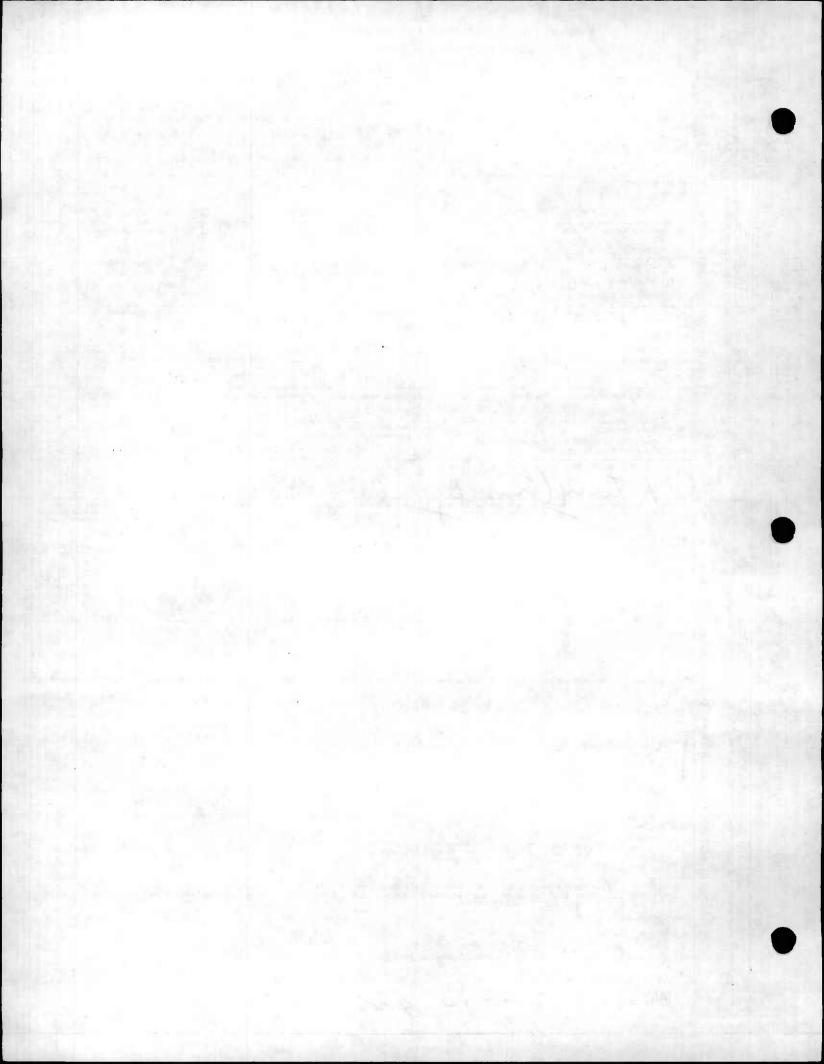
9000 Franklin Square Dr. ve Baltimore

n (Item 23a) (Type, Print)

completed cause of dear

32. Registrar's Signatura

Augeung



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Time of Deeth Year **Physician** LESTER HOPKINS 0350 AM MAY 2000 29 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** HOWARD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA 7. Age (In yrs. lest birthday) | ff Undar 1 Yaar | ff Undar 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex Birthplece (State or Foreign Country) MM 20F Yrs. 173-12-6547 April 17, 1920 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 1415 Shore Road 21220 U.S.A. 12. Wes Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Merital Status Bleck, White, etc. Armed Forces? 1 No 1944— If Yes, Give Yaar or Detas: 1945 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Supervisor Warehouse 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) James Hopkins Alice Williams 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Lynne Rice (daughter) 10162 Bracken Drive, Ellicott City, Maryland 21042 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Slete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Duvall Cemetery 6/2/2000 5Mile Run, Pa. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Puneral Service License 22. Neme end Addrass of Fecility Bruzdzinski Funeral Home, P.A. 1407 Old Fastern avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part1. En If the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, the figure. List only one cause on each line. SEPSIS Immediate Cause (Final disease or condition resulting in death) 10 DAYS Due to (or es e consequence of): DOCARDITIS Sequentially list conditions, if eny, leeding to immediate ceusa. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): NELLMONNIA Physician/Medicai Due to (or es a consequence of) INFECTION TRACT Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown D15878 Completed by 24b. Were autopsy findings available prior to complation of ceuse of death? DISTASE 24a. Wes en eutopsy parlormed? PART 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 DInpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Box 68760. P.0. Records, of Vital Division or Attending

Funeral

Director

8

Maryland 21215-0020

Baltimore,

nt of Health and Mental Hygiene.
If them 27 is merked other the

Department of H Important: If the any injury or of

Physician

/Medical Examiner

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Pages 1 and 2 should

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After

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I Director: Aft din by the fur

Hospital

filled in by

State Registrar

RASAR ABU 31. Dete filed (Month, Dey, Year)

29b. Signature end title of certifier

29a. Certifier

(Check only

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Dey, Year)

30. Name end address of parson who completed ceuse of deeth (Item 23a) (Typa, Print)

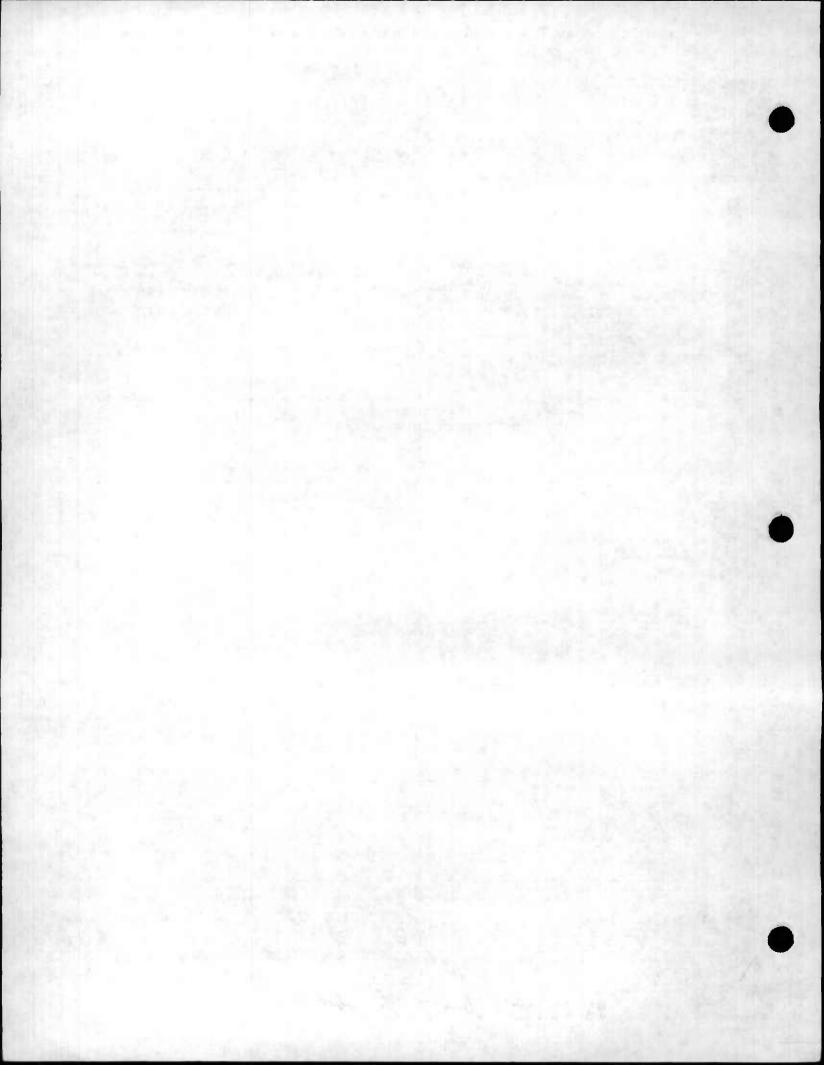
MAY 29 COLLEGE PARK MD. 20740

6201 GREENBELT m. 9.

32. Registrer's Signeture

ROAD, SWITE M-14

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Yaar 5.45 Pay da Johnson Ma 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Haspita 1 Comt General Columbia ounty Would Min. 8. Date of Birth (Month, Day, Year) 9. Birthpleca (Stata of Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 68 Yrs. **Funeral** Days 1 M 2 DXF 577-42-8977 Director 10 - 07 - 31MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director or 28a-f MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerns 23a 3501 EDGEWOOD RD 21215 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Raca - American Indian, Black, White, etc. ould be filed within 72 hours after Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry al Hygiene. U.S. Elementary/Secondary (0-12) College (1-4or 5+) 10 SUPERVISOR POST OFFICE of Health and Mental Hygie filtem 27 is marked other in other traumatic event, to Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) permit. Pages 1 and 2 should by Department of Health and Menta Important: If Nem 27 is marked any injury or other traumatic as JAMES ALTON PROCTOR ROSETTA NEWMAN 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JILL J. BELL/DAUGHTER 5578 LINTON RD. SYKESVILLE, MD 21784 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METRO CREMATORY 5/31/2000 BALTO., MD. 4 □ Donetion 5 □ Other (Specify) Signature of Funeral Service Licensea 22. Name and Addrass of Facility
JAMES A. MORTON & SOMS F.H., INC V -on 1701 LAURENS ST. BALTO., MD. 21217 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Septic disease or condition resulting in death) Examiner by Physician/Medical Examiner Resisfant Conterococci The law requires that the death certificete be asscuted attending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the undertying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy Hostructure Polanoncy Oscose this certificate hes 1 Pres 2 No 1 Tyes 2 No bleeding Menos Failure Division of Vital sepital or Attending Physician: The hours after death.

Juneral Director: After this certificate by filled in by the funerel director, pe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 ☐ Suicide 28e. Place of fnjury - At homa, farm, straat, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 724 elean Cittle 32. Registrar's Signature State 2000 Registrar

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17165

				Certifica	ate of L	Death		Reg. No.	0 1/16;	
Physician	1. Decedent's Name (First, Middle, L		5	ONE	2		2. Dale of De Month	Day	Year 17:47	
/Medical Examiner	4e Facility Neme (If not institution, gr BON SECOURS HOS	ive street and number)				b. City, Town, or BALTIM	Location of Deat	h 4c. County		
Funeral Director	5. Social Security Number 6. 219-66-5193	Sex 7. Ag	e (In yrs. last i	Yrs. If Un Month	der 1 Yeer ns Days	If Under 24 Hrs Hours Min.	8. Date of Big (Month, Da 12-27	th ly, Year) -1955	Birthplace (State or For Country) MD •	
Hed at	Usual Residence of Decedent 10a. Stete 10b. County MD . N/A			wn or Location					10d. Inside City Lir 1 XYes 2 □	
23e or 28e-f sho ust be notified at ral Director	10e. Street and Number 1118 N. LAKEWOO	D	344	10f.	Zip Code	13		10g. Citizen of V USA	Vhat Country?	
Examiner in by Fune	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 2 H If Yes, Give Year or Dates:			V	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	14. Rac Blac	e - American Indian, sk, White, etc.	
ygene. wr than 'netur t, the Medical. Completed	15. Decedent's 8 (Specify only highest gi	rade completed)		Se. Decedent's U (Give kind of life. DO NO	sual Occupa work done d Tuse retired)	ation furing most of wo	rking	16b. Kind of Bu	usiness/Industry	
Com	-8 -	College (1-4or	D+)	LABOR	RER			CONSTR	UCTION	
B week	17. Father's Name (First, Middle, Las							, Maiden Surnam	e)	
d Men marks maric	JOSEPH K. JONES 19a. Informant's Name/Relationship		110	Ob Mailing Addr	acc /Straat o		UDE COM		State, Zip Code)	
27 is 27 is r trau	RONALD JONES (BR		"			ST. BAL				
ent of He at: If Rem by or othe	20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 4 □ Donetion 5 □ Other (Spec		ceme	of Disposition (// tery, crematory of MEMORIAL	or other place		Date -1-2000		City or Town, State RE, MARYLAND	
Departm Importar any injur ance.	21. Signature of Funeral Service Lice		ld	22. Name	and Addres	s of Facility RE	DD FUNE	RAL SERV		
ysician Medical aminer	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		PSI Due to (or as	a consequence	of):	VDEE!	CIEN		Interval Between Onset and Deat	
physician and s the buriel-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. 77 CQ0	Due to (or as a consequence of):					NORON	15	
Me as	resulting in death) Last	d	Due to (or as	a consequenca d	of):					
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should should								an autopsy ormed?	24b. Were autopsy findir available prior to completion of cause of death?	
page 2							10	Yes 2 No	1 ☐ Yes 2 ☐ No	
Be Be	25. Was case referred to medical examiner?	Hospital:	><		Othe	DF*	ath (Check only			
8 D	12 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28t	Outpatient 3	DOA Othe	4 Nursing r		denca 6 Oth		
within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral Medical Certification: 1	2 Accident 5 Pending 2 Accident investigation 3 Suicide 6 Could not determine	(Month, Da	(Month, Day Year) Injury Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office 28f. Li					18f. Location (Street and Number or Rural Route Number, City or Town, State)		
Funeral Dit rely filled in Ical Cer	29a. Certifier Certifying P	hysicien; To the best miner: On the basis o	of my knowled f examination	ge, death occurr	ed at the tim	ie, date and place	a, and due to the	cause(s) and ma	anner as stated. and due to the cause(s)	
within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.									
T the			29c. License number 29d. Date signed (Month, Day, Year) LEN JMJ D3 1793 5-24-00 completed cause of death (Item 23a) (Type, Print) PALTIMORE ST BAltimore Md 2122							
To the comple	29b. Signature end title of cartifier	glan 5 m	7	2	031			5-2		

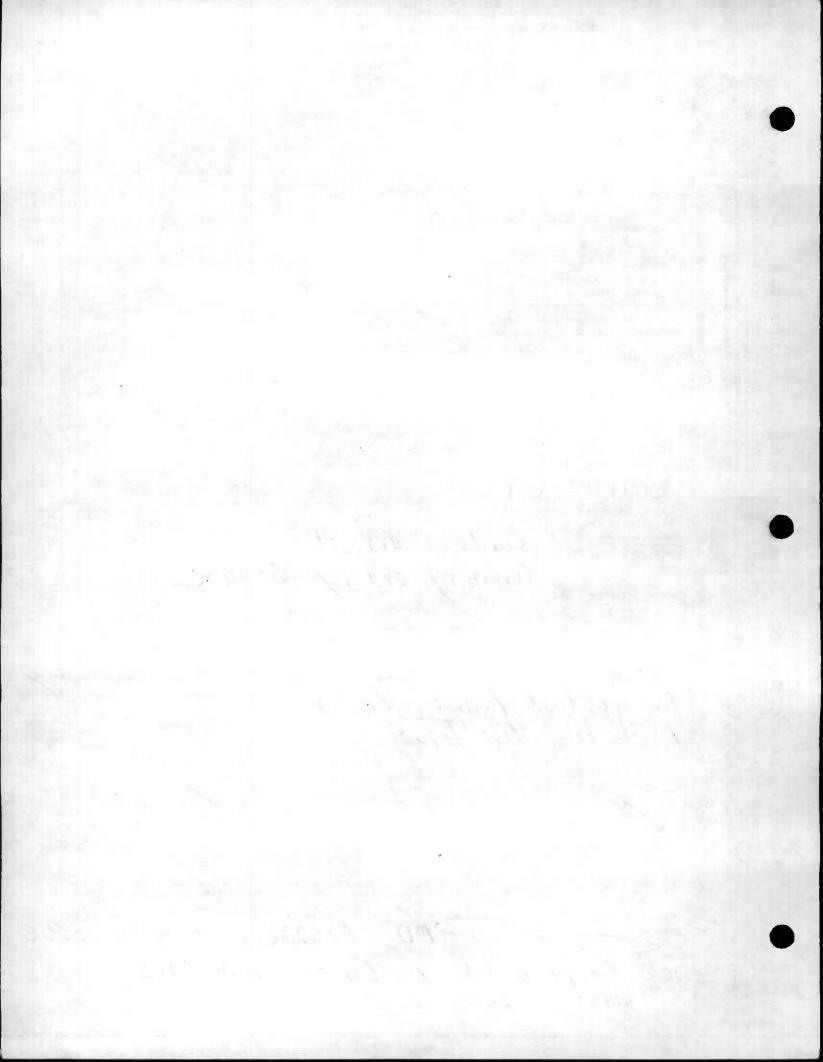
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30 2000 May Harold E. Kelly 5:30AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 922 Circle Drive Arbutus Baltimore If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) **Funeral** MAM 2DF Months Days Hours Yrs Director March 23,1923 219-12-1229 Pennylvania Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryla Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28e-f show say injury or other traumatic event, it a Medical Exp. item must be not extent. 1 ☐ Yes 2 No Director Maryland Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 922 Circle Drive 21227 United States Funeral 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 HNo 11. Marital Status 1 Never Married Married 21215-0020 1 Yes 2 IXNo Specify: Yes. Give Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 12 Chauffer Trucking Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be James W. Kelly Elsie McCoy 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby C. Kelly (Wife) 922 Circle Drive Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20s. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 30 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Hostontown Cemetery 6/2/00 Hostontown, PA 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death **Physician** Cardiac immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequ Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury Box 68760. that initiated events resulting In deeth) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause, given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Nonknown Records. þ 24b. Were autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 No 1 □ Yes 2 □ No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Medical Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Divatural 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of de Item 23a) (Type, Print) 31. Date filed (Month, Day, Ye. 32. Registrar's Signature State MAY 3 1 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 Decedent's N	ame (First, Middle, Las	pt)					2. Date of	Reg. No.	2.7	ime of Death
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I Director	10e. Street and	Number - O Shore H	larbor Dri	17.0	10f.	Zip Code	2007/		10g. Citizen of	What Country?	
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by Fur		arried 2 Married	Armed Forces? 1 🕅 Yes 2 🗍 ñ If Yes, Give Year or Detes: [specify Cuba s 2X No	Specify:	ierto Rican, etc.)		ock, White, etc.	
be		15. Decedent's Ed	ucetion		Se. Decedent's U	Isual Occup	etion		16b. Kind of B	Susiness/Industry	
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State Registrar

31. Date filed (Month, Day, Year)

JUN 0 7 2000

32. Registrer's Signature

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29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

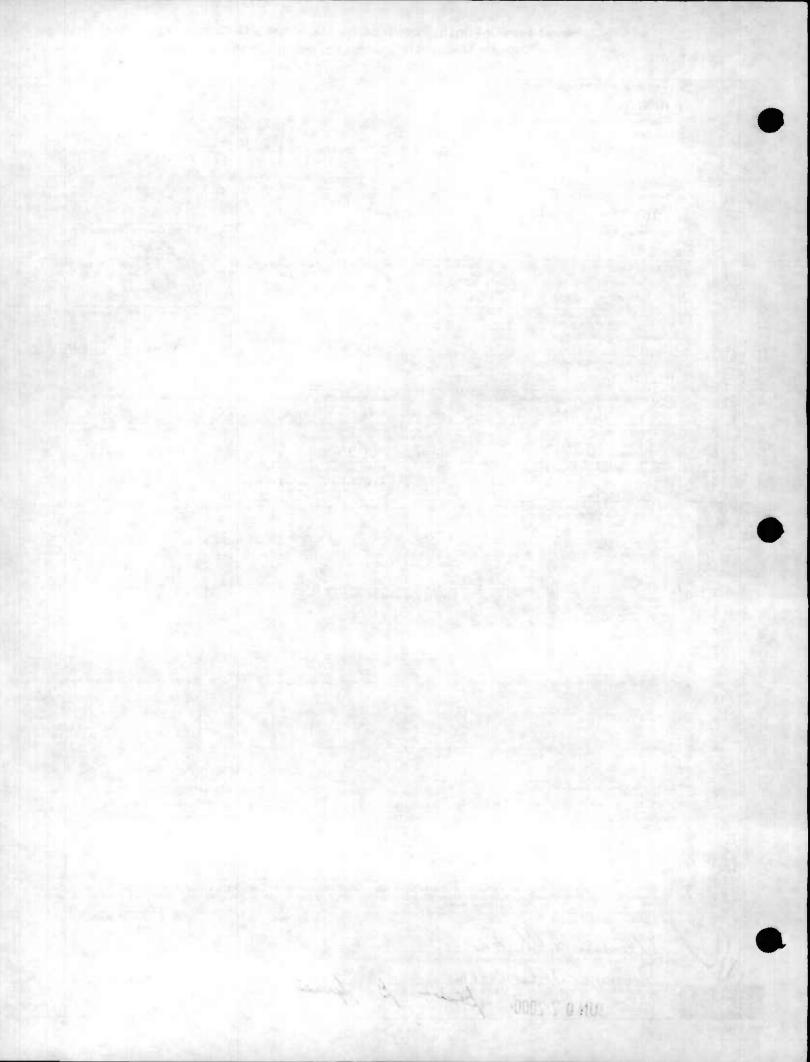
32. Recistrer's Signature

29c. License number

O.C.M.E.

29d. Dete signed (Month, Dey, Year)

May 27, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** FRANK SANDS KISER 2000 5 12:55 AM 26 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 220 N. Heron Dr. Apt. 6 Ocean City Worcester | H Under 1 Yaar | H Under 24 Hrs. | 8. Dete of Birth (Months, Days Hours | Min. | 1/20/39 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 125 M 2 F Mary land 212-38-0873 61 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10c. City, Town or Location 28a-f show MD Worcester Ocean City 1X Yes 2 □ No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 23a or 220 N. Heron Dr. Apt. 6 21842 USA Funeral **Herne** 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status 14. Race - Amarican Indian, Black, White, etc. if Hygiene. other than "natural", or its 1 ☐ Yes 2X No If Yas, Give Yaar or Datas: 1 ☐ Nevar Married 2 ☑ Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 Divorced Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elementery/Secondery (0-12) F. Sands Interprize Contractor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lujury or other traumatic event plats. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be John Franklin Margaret Sands 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Heron Drive, Ocean City, Maryland 21842 Mrs Dorothy L. Kiser (Wife) 220-6 20b. Plece of Disposition (Nema of cametery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriei 2 Cremation 3 Removel from State St. James Cemetery 5-30-00 Monkton, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. Wallace 1050 York Road, Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tntarval Between Onset end Death **Physician** with Metatasis anux Immediata Cause (Finel disease or condition resulting in death) /Medical 0 Examiner Due to (or es e consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last attending physician and for use as the burial-tran Due to (or es a consequence of) Box 68760, Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, ð page 2 should b 24b. Wara eutopsy findings available prior to completion of cause of daeth? Completed 24a. Was en autopsy performed? 2.0 No r this certificate haral director, page 1 Yes 20 No 1 Yes Division of Vital tal or Attending Physician: The state death.

In Director: After this certificated in by the funeral director, pe Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 Naturei 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be datarmined 28e. Pieca of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di complately filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Cartifian (Check only one) 29b. Signeture and titla of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) nnah

32. Registrar's Signeture

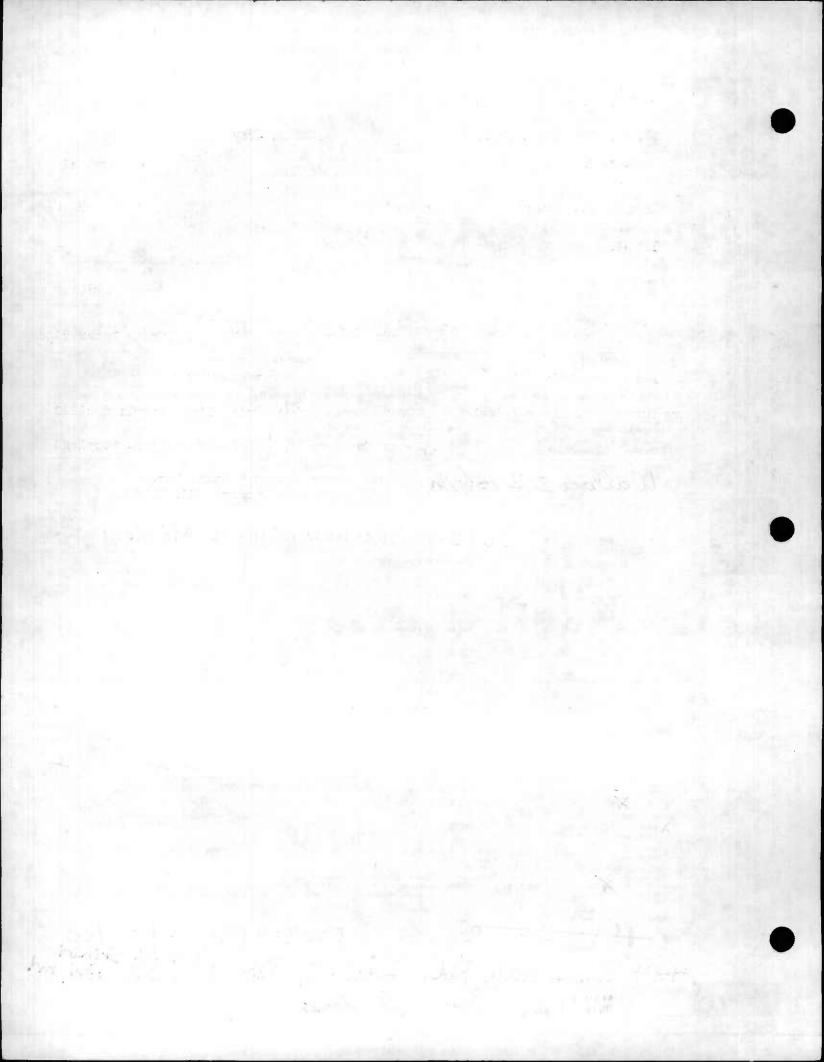
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31. Date filed (Month, Day, Year)

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DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

death certificate be executed

Box 68760

P.0.

Division of Vital Records.

29b. Signature | Wile of certifier

31. Dete filed (Month, Day

Jude

State

Registrar

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Muneses

MD

32. Registrer's Signeture

ORIGINAL

7845

29c. License number

OAKWOOD

porks

D53462

29d. Date signed (Month, Dey, Year)

Road Baltmore, mb 21061

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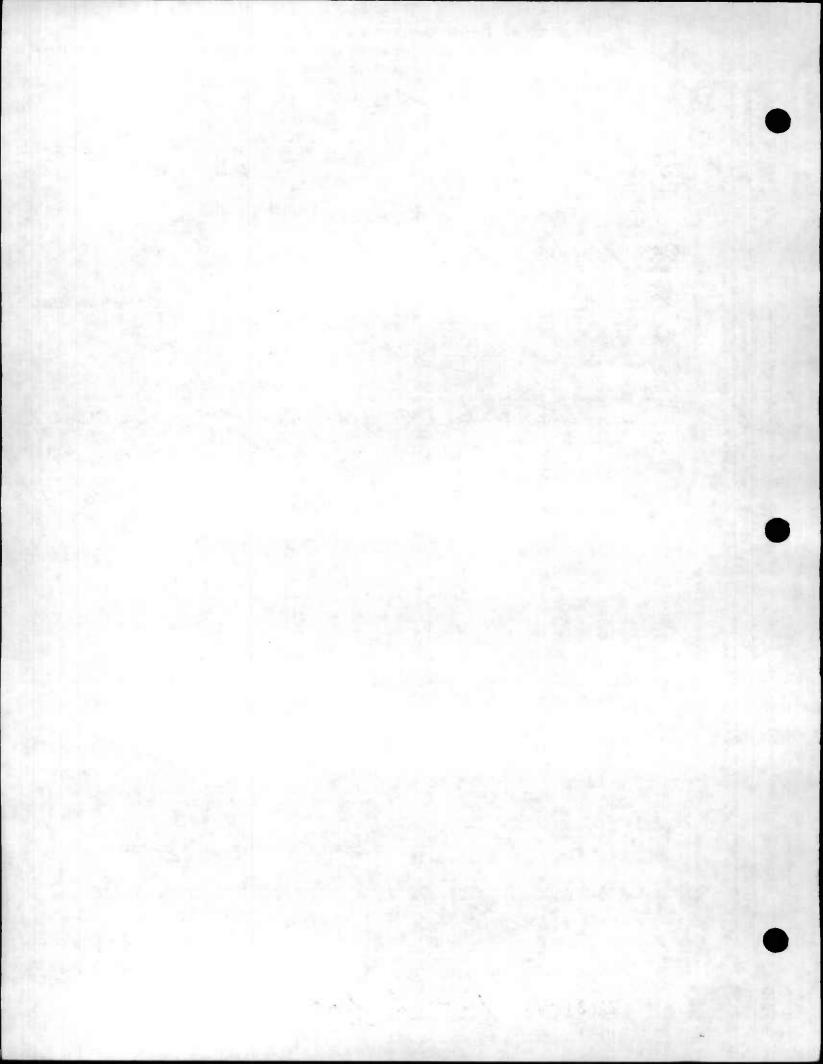
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 8 Month **Physician** LINTON 404E44A 46 AM MAY 2000 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner HOSPITAL CEN BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) 5. Sociel Security Number Sex 1□M 2VF **Funeral** Months Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at BALTimore Yes 2 No NA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in Armed Forces?
1 Yes 2 No If Yes, Give Year or Data Funeral 14. Raca - American Indian, Bleck, White, etc. 11. Marital Stetus permit. Peges 1 and 2 should be filed within 72 hours effer Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercise. 1 Never Merried 2 Married 1□ Yes 2000 3altimore, Maryiand 21215-0020 Specify: þ Africian American 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be 2 ovella Howard 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BAGMAN, ND. 21244 20c. Location - City or Town, Stete Jacqueline LINION 20b. Pleca of Disposition (Name of pemerery, crematory or other place) Date 20a. Method of Disposition 1 Surial 2 ☐ Cremetion 3 ☐ Removel from State □ Donetion 5 □ Other (Specify) lem Park 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or corp. ations that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart feiture. List a sone cause on each line. Physician /Medical SUBARACHNOID 7 DAYS Immediate Cause (Finat HEMORRHAGE disease or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca of): Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ed by the a 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed END STAGE RENAL DISEAS 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) Certification: 28c. tnjury at Work? After t al or Attending P s after death.

If Director: After by the funer 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is Certifying Physician: To the best of my knowledge, death occurred at the time, dete and pleca, end due to the ceuse(s) end manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P12/36 Mb hos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -OXCEY, MD S. HAKOVER ST. BALTIMORE. TAKG 3001 32. Registrer's Signeture 31. Date filed (Month, Day, Year) State MAY 31 Registrar

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #27 PER PHY G783 5-30-00 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** Cynthia 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Sex 7. As 1 M 2 RF Baltin If Under 24 Hrs. 1 dias Baltimore County niversit more 8. Dete of Birth (Month, Dey, Yea 09/27/48 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (State of Foreign Country) We.S.L. Deys Yrs. 232-76-2167 51 Lewisburg, Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director PA York York, PA 17403 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2025 S. Queen St., #222 17403 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 14. Rece - American Indian. Bleck, White, etc. 1 ☐ Never Married 2 Merried 1 Yes 2 No Specify. Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Radiation Oncologist Medical 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumerne) Charles W. Lewis, Jr. Margaret M. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2025 S. Queen St., #222, York, PA Clifford T. Kish / Husband

Heffner Funeral Chapel & Crematory

Dete 5/18/00

22. Name end Address of Fecility

-014569-L

York, PA 17404

Heffner Funeral Chapel &

Crematory, Inc., 1551 Kenneth Rd., York, PA 17404

Physician /Medical Examiner

Permit. Pages 1 and 2 abouid be filed within 72 hours after deat Department of Heelth and Mental Hygiene. Important: if them 27 is marked other than any injury or other trainings.

20a. Method of Disposition

1 ☐ Burial 2 In Cremetion 3 ☐ Removel from Stete

4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee

Funeral

Director

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To the Hospital or Attending Physician: The law requires that the death certificate be assouted within 24 hours after deeth.

To the Fueral Director: After this certificate has been signed by the attending physician and completaly filled in by the funest director, page 2 should be deteched for use as the burishiransit completaly filled in by the funest director, page 2 should be deteched for use as the burishiransit physicien and is the burief-transit

Division of Vital Records, P.O. Box 68760,

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25. Was case referred to medical examiner?			26. Place of De	eeth (Check only one)	
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27. Manner of Death 1 Anetural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	rred
3 ☐ Suicide 6 ☐ Could not be determined		nome, ferm, street, factor	y, office	28f. Location (Street and Number City or Town, State)	ber or Rurel Route Number,
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29b. Signature and the of certifier		29	c. License number	29d. Date signe	ed (Month, Dev. Year)

State Registrar **DHMH 16 Rev 6/95**

31. Date filed (Month, Day, Year) MAY 0

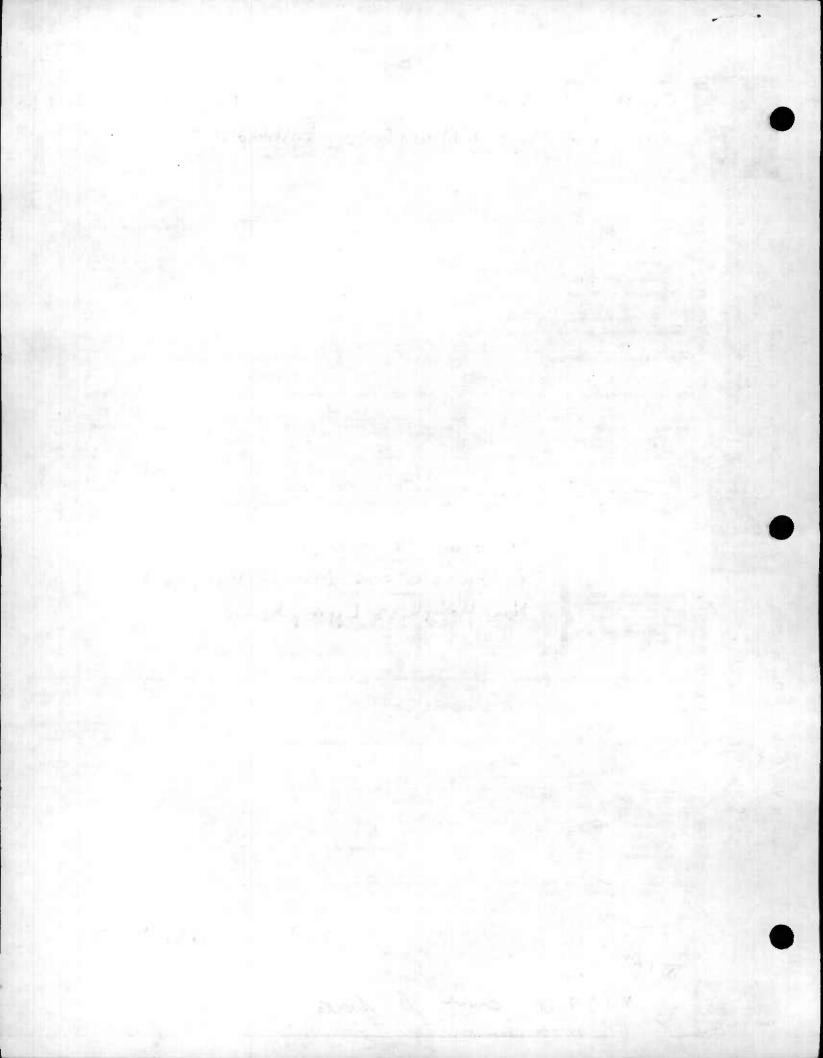
30. Name

20

32. Registrer's Signeture

of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 28 1:30PM James Harrison Mitchell May 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 707 Maiden Choice Lane Apt. 8 G03 Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days NOXM 20F Yrs 216-03-2611 84 Director May 14, 1916 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Baltimore Maryland Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 707 Maiden Choice Lane Apt. 8 G03 21228 Funeral United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Merried 2 Married b 3altimore, Maryland 21215-0020 1 Yes 2€KNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondery (0-12) College (1-4or 5+) Machinist Machine Production 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Isan 27 is marked other any injury or other traumatic event 17. Father's Neme (First, Middle, Last) Be Marion Charles Mitchell Florence Summerlock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 19a. Informent's Name/Relationship (Type, Print) Josephine J. Mitchell (Wife) 707 Maiden Choice Lane Apt. 8 G03 Catonsville, MD 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State Meadowridge Memorial Park 6/1/00 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FecilityAmbrose Funeral Home, Inc. 21. Signature of Funerel Service License p 1328 Sulphur Spring Road Arbutus, MD 21227 used the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on line. 23a. Pert1. Enter the disease, or complications that a shock, or heert failure. List only one course and a shock or heert failure. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Darkinsons Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or es a consequence of) 88 USB been signed by the a should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 s 1 ☐ Yes A ☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? or Attending 5 Pending death. 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral D Medicai 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 1 2 4

DHMH 16 Rev 6/95

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State

Registrar

29b. Signature and title of certifie

31. Dete filed (Month, Day, Year)

MAY 3 1 2000

711

Maiden

MD

Choice

(and

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

souls

29c. License number

D4744)

atons ile

29d. Dete signed (Month, Day, Year)

2000

DR ANDREW LAZAS

May 30

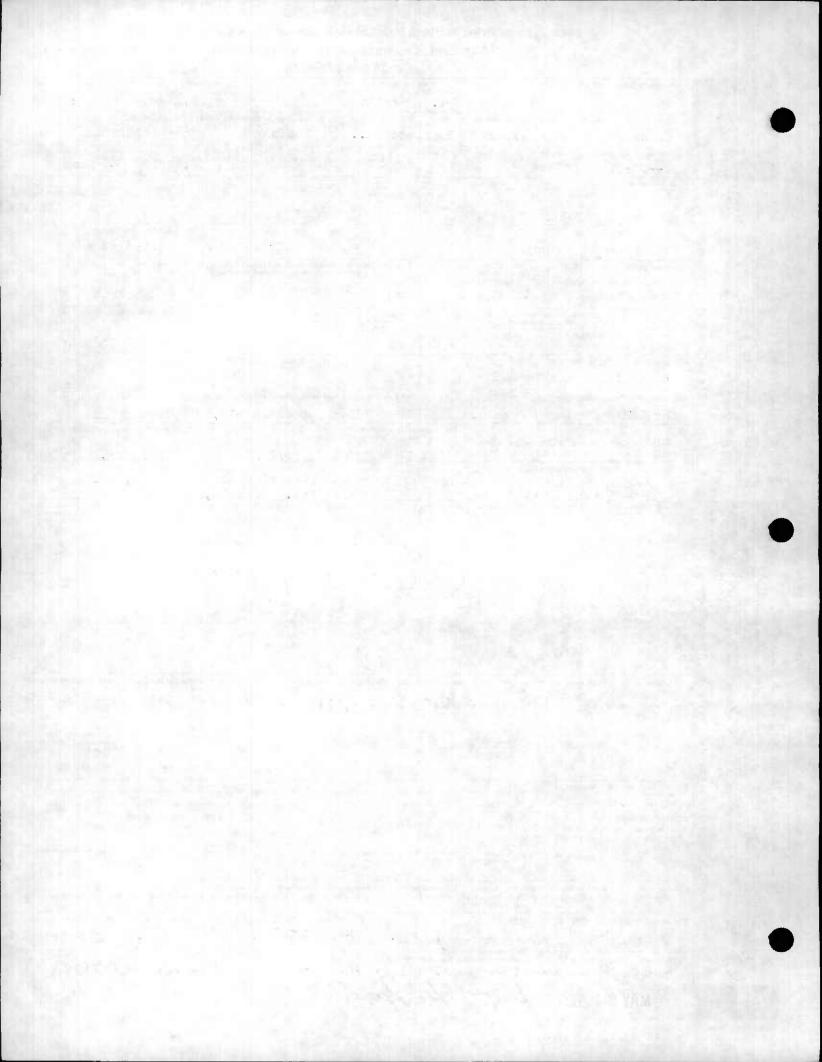
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month May 28, 2000 **Physician** 4:05 AM Wanda Mally /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Genesis Heritage Meridian Eldercare Ctr. Baltimore Dunda1k 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) July 21, 1913 9. Birthplace (State or Foreign Country). New Jersey **Funeral** Months Hours 11 M 2 € F 86 220-01-3881 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes No Director Dundalk Maryland Baltimore 28a-f 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21222 United States 2516 McComas Avenue Funeral 14. Reca - American Indian, Bieck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married ð Maryland 21215-0020 1 Yes 2₺ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Tin Mill Steel Industry 6 Years 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) Josephine Mita Benjamin Krawczykowski 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Geraldine Hoxter (Daughter) 1814 Tyler Road Dundalk, Maryland 21222 altimore, 20b. Pleca of Disposition (Neme of 20c. Location - City or Town, Stata 20a. Method of Disposition Date cemetery, cremetory or other place) 1XXBuriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Oak Lawn Cemetery 5/31/2000 Baltimore, Maryland 21. Signature of Funeral Service Licenties 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 and the mode of dying, such as cardiec or respiratory errest, the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, the deeth inc. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) FATILURE /Medical CONGESTIVE HEART Examiner Physician/Medical Examine DISEASE CORONARY AR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): 68760. Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown WITH RIGHT HOMIPLEGIA. The law requires that à of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed funeral director, page 2 s this certificate has 1 Yes 2 No 1 Yes 20 No al or Attending Physicien: The safter death.
If Director: After this certificated in by the funeral director, pages of the funeral director director, pages of the funeral director director, pages of the funeral director direct 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Injury 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of celtific 5-30-2000 D17753. · Com purpose. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Y 710 CHURCHST. BALTIMORE, MD 21225

Registrar **DHMH 16 Rev 6/95**

· S. DHARMASTNA, MOD.

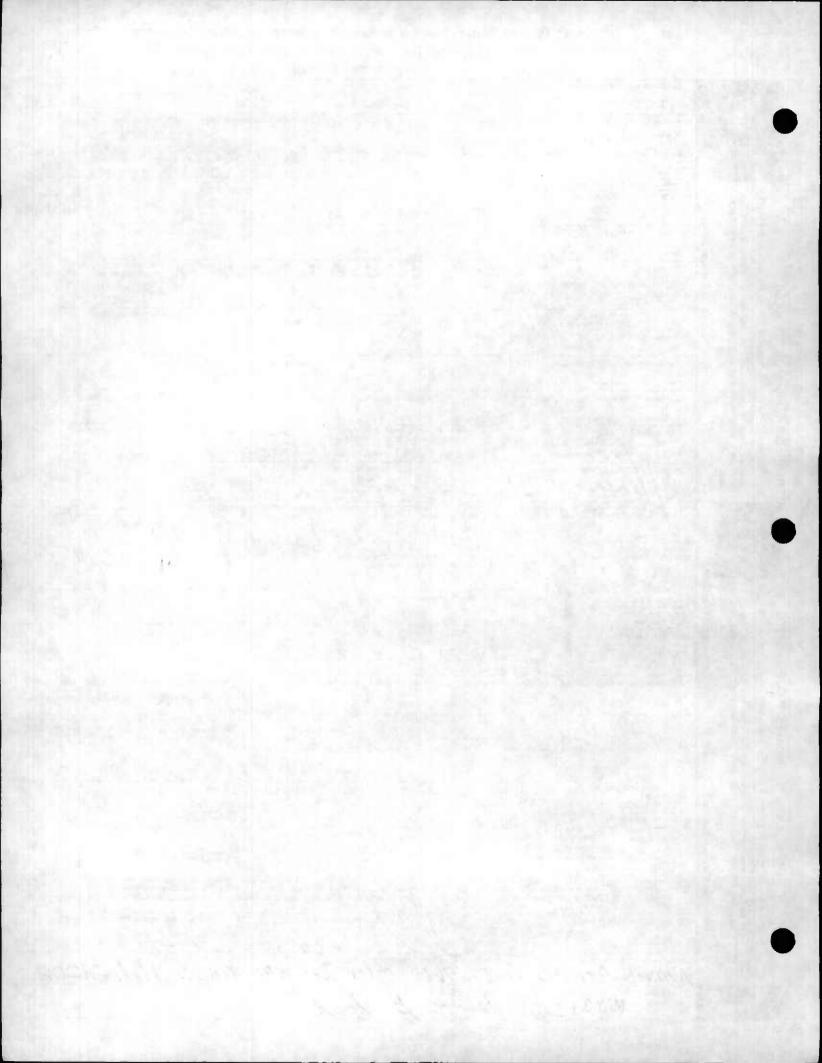
32. Registrar's Signator



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

				State of W	aryland / L	Certificate of			eg. No.		1113
	Dhlalaa	1. Decedent's Name (F	irst, Middle, Las	1)			No. of the	2. Date of Dear Month		Year	3. Time of Death
qį	Physician /Medical	BERNADETT	E	c.		MAFALE		MAY	23, 200	O	6:50 P.M.
	Examiner	4a Facility Name (If no	t institution, give	street end number)		4b. City, Town, or Lo	ocation of Death	4c. County o		
		3237 CONO				William Wa	T KU2-4 6411		HARF		
	Funeral Director	5. Social Security Numb	7	7. A	ge (In yrs. lest bir 69	thdey) If Under 1 Year Months Days		8. Date of Birth (Month, Day 4/1/31			lece (State or Foreign try)
	pue & w		b. County		10c. City, Tow	n or Location				10	Od. Inside City Limits
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	ath with the Maryler 23s or 28s-f show LEST De notified all rel Director	10e. Street and Number	r			10f. Zip Code		1	0g. Citizen of W	hal Coun	try?
	23a c	3237 CONO	WINGO RO	מער		21154	1		USA		
	r teme 23a	11. Marifal Status	111100	12. Was Decedent Armed Forces	Ever in U,S.	13. Was Decedent of If Yes, specify Cut		ecify Yes or No- Rican, etc.)	14. Race	- America	an Indian,
21215-0020	by	1 Never Married 3 Widowed 4	2 Married Divorced	1 Yes 2 N If Yes, Give Year or Dates:		1□Yes 2⊠No			Specify:	WHIT	
5-0	ed within 72 ho ygiene. er then "neturn ft, the Protest Completed	15. (Specify o	Decedent's Edi	ucation le completed)	16a.	Decedent's Usual Occu (Give kind of work done	during most of work	ing	16b. Kind of Bus	iness/Ind	lustry
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an	Se Se							OSENBERG			
Maryland	2 should and Man is marks sumatic To	JOHN MENT 19a. Informant's Name		vna Print)	19b	. Mailing Address (Stree				State. Zip	Code)
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Baitimore,	-155	ANTHONY MA 20a. Method of Disposit	tion			Disposition (Name of y, crametory or other ple	NGO ROAD	Date	20c. Location - C	city or To	wn, State
E	80= 5	1 Burial 2 C						27 /2000	DALMIN	ODE	MD
aiti	permit. Pa Departmen Important: any injury ang injury	21. Signature of Funera			MOST F	OLY REDEEMS 22. Name and Addr		27/2000	BALTIM	UKE	MD
m	S S E S S	1 /len4	hen 11.	Lluis		THE JOHNSO	N FUNERAL	HOME, I		212	0.0
		23a. Part Enter the d	liseese, or comp	lications that cause	d the death. Do	8521 LOCH not enter the mode of dy			SON, MD est,	212	Approximate
	Physician	hock, or heart ta	ilure. List only o	ne/cause on each	ine,	,	1.				Interval Between Onset and Death
	/Medical	Immediate Cause (Final disease or condition	al	1	12h	1 M 01	LIRCOLA	10		-	2118046
	Examiner	resulting in death)		. 1	Due to jor as a	consequence of):	M Car	7	/		5900
	D # 5	10000			0						
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68760,	clan a	Sequentially list conditi if any, leading to imme- ceuse. Enter Underlyin Cause (Disease or inju-	ng J	0							
87	flicate be executed physician and as the burial-transit edical Examir	that initiated events rasulting in death) Last		7	Due to (or as a	consequence of):					1,14, 23,150
			-	d.						i	
Вох	that the death cert ed by the attendin detached for use / Physiclan/M										
P.O.	the dy the ched	Part II. Other significan	nt conditions co	ntributing to death i	out not resulting in	the underlying ceuse g	iven in Part I.		41		the cause of death?
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rds	requires that the death cereen signed by the attending hould be detached for use etect by Physician/Netection.							24a. Was a	in autopsy	24b. We	era autopsy tindings
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tal	certificate rector, pag	25. Was case referred	to medical				ne Blass of Deat	1 Y			Yes 20 No
5		examinar?	-	Hospital:	ent 2 ER/Ou	tpatient 3 DOA	26. Place of Deat ther: 4 Nursing Ho	Az	ence 6 Othe	r /Snecih	v)
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ion	Attending For deeth. octor: Atter by the funer iffication:	1 1 I I I I I I I I I I I I I I I I I I	Pending investigation	(Month, D	sy rear)		Yes 2 No				
	bal or Attending P is after deeth. al Director: After t ed in by the funera Certification:	3 Suicide 6	Could not be determined	28e. Place of In building, e	jury - At home, fe tc. (Specify)	rm, street, factory, office		28f. Location (S City or Tow	treet and Numbe n, Stete)	r or Aura	I Route Number,
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	the Hospital or Atte vin 24 hours after de the Funeral Directs repletely filled in by the Tedical Certific	29e. Certifier \$2 (Check only 2 one)	Certifying Phy Medical Exam	sician: To the best iner: On the basis of and manner s	of examination an	death occurred at the to for investigation, in my	ime, date end plece, opinion, deeth occur	and due to the d red at the time, d	ause(s) and mar late and place, a	ner as st nd due fo	ated. he cause(s)
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	140	30. Nama and address/	ot person who c	ompleted cause of	death (Item 23a)	(Type, Print)	470	-	~	2 6	
	m	AYMAN Y	AKHA	O. M.I	. 760	Osler -	2736 DR. #41	1 Tows	on, 11	d. 0	21206
	State	31. Data filed (Month, C	11/6	. /	rar's Signature	1. 1					<u>,</u>
	Registrar	MA	Y31 20	100	pera	D span	1/2				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year MITCHELL 4.38 AM DEBORAH MAY 2 2000 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death HOSPITAL CENTER ROSENALE Square FRANKLIN 5. Sociel Security Number BALTIMORE MUnder 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 6 Sax Birthplace (State or Foreign Country) Months Days 1 □ M 2 08 F 220-50-2449 Yrs. MC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ② No ARKVIII BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? AVE 21234 ORLANDO 4.5 A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritat Stetus 1⊠Never Merried 2□ Merried 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5.5 CLERK ADMIAS 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) TORD JOAN KENNY 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other place) BAHOND 21224 KEGINA 20a. Method of Disposition Dete 1 ☐ Burlel 2 ☑ Cremetion 3 ☐ Removal from State 31/00 4 ☐ Donation 5 ☐ Other (Specify) NMOUNT 22. Name end Address of Fecility Home CATD. 21. Signature of Funeral Service Licensee x/6/Md 21234 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Ceuse (Finet disease or condition resulting in death) Escherichia Coli DAYS Due to (or as a consequence of): Respitou Doul+ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): TINARY Infection ract thet initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Department of Health ar Important: If Item 27 is

Physician

/Medical

Examiner

Director

Be

Funeral

Director

à

Saltimore, Maryland 21215-0020

Mitchell

1 Yes 2 No

27. Manner of Daeth

1. Naturel

2 Accident 3 Suicide

4 ☐ Homicide

MAY 3 1 2000

29a. Certifier

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; s

The law requires that the death certificate be execu

Box 68760.

Records.

Vital

Division of

Physician/Medical Examiner Completed by Be Medical Certification: To

31. Date filed (Month, Day, Year) Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baba ali HOSSEIN.

5 Pending investigation

6 Could not be

29b. Signeture end little of certifier

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and menner steted.

28a. Date of Injury (Month, Day Year)

9000 FRANKLIN 32. Registrar's Signature

1⊠Inpatient 2□ ER/Outpatient 3□ DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

29c. License number

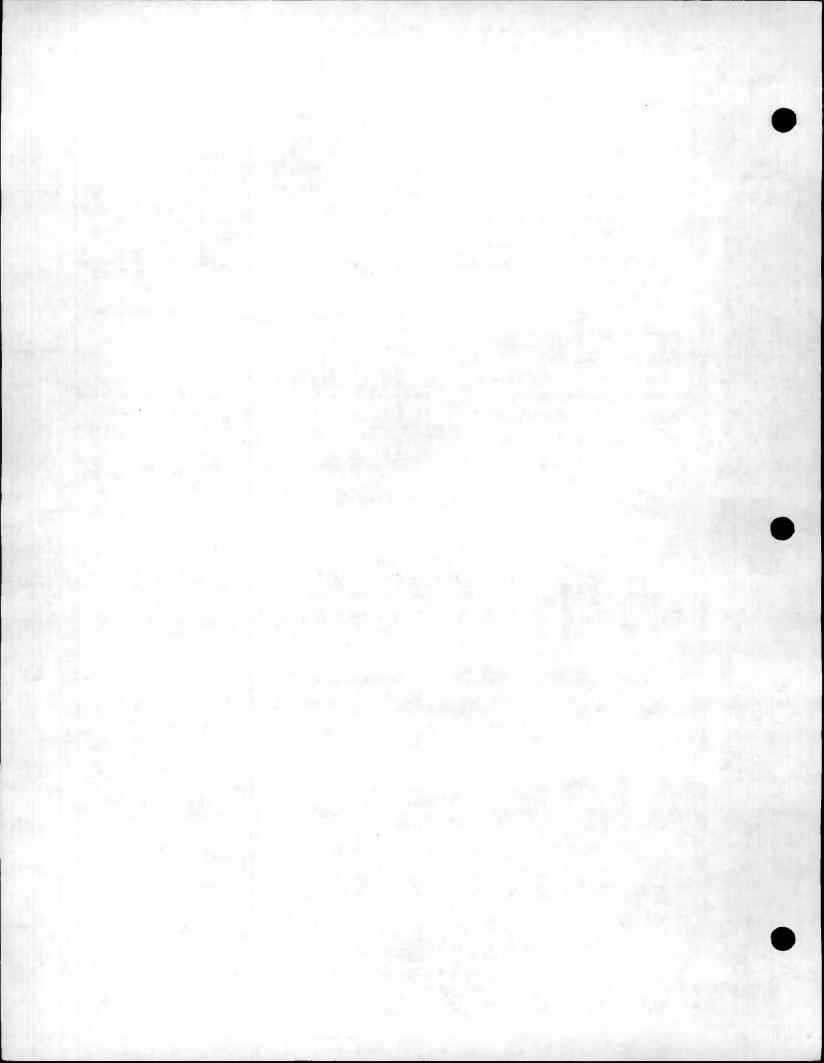
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🖄 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

gene + DRIVE, BOHMORE, MARYLAND 2123

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 28, 2000 3:45 PM /Medical Richard H. Merchant 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 5.28-00 3:45 PM Hospice Of Baltimore Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (Stete or Foreign Country) On 10 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□ F Days Yrs 83 Director 370-01-9889 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Director Cockevsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 International Circle U. S. A. 21030 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No WWII I Yes, Give Year or Detes: White 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry RICHARD Elementary/Secondary (0-12) College (1-4or 5+) ITT & Sterling Abrisives Sales Manager 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 12 should be fi h and Mental H UNKNOWN UNKNOWN UNKNOWN UNKNOWN 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 Health a 10535 York Road, Cockeysville, Maryland 21030 Mrs Janet R. Merchant (Wife) Pages 1 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Buriat 2 Cremetion 3 Removel from State 4 Donation 5 □Other (Specify) Dulaney Valley Mem. Gards. 6-1-00 Timonium, Maryland 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximete tntervat Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical End-Stage reun (disense Examiner mellitus Physician/Medical Examiner VIA betes The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2NNo 3 Probably 4 Unknown ate has been signed page 2 should be de Records, ٥ 24b. Were autopsy findings aveilable prior to Be Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital or Attending Physicien: 25. Wes case referred to medicat 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) + 0 Spice 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Division 1 Naturat 2 Accident 5 Pending investigation Ne Hoepital or Attending in 24 hours after death. The Funeral Director: After 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stele) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Scortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated. I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical compietely within 2 To the 29b. Signature and the of sertifie 29c. License number 29d. Date signed (Month, Day, Year) (ttem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State Registrar

DHMH 16 Rev 6/95

32. Registrar's Signature

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 17178

				Certificate of	Death		Reg. No.	, 1	1110
144	1. Decedent's Name (First, Middle, L.	ast)				2. Date of D		Year	3. Time of Death
Physician /Medical		Richard	d John Ma	eby, Jr.		May 2	Month 26, 2000 Year 1:30 P		
Examiner	4a Facility Name (If not institution, gi Johns Hopkins E	or Location of Dea							
Funeral	Social Security Number 6.	Sex 7. A	ge (In yrs. last birth	day) If Under 1 Yea		Min. (Month, D	irth lay, Year)	Cour	place (State or Foreign
Director	177-30-7576 Uaual Residence of Decedent	23.	62 Y	rs.		Nov.	24,1937	Mar	yland
and tand	10a. State 10b. County		10c. City, Town	or Location				1	Od. Inside City Limits
with the Maryland ta or 28a-f show the notified at	110.27 - 111.11	ltimore			Dunda 1	K			1 □ Yes 2 □ No
23a or 2	10e. Street and Number 8220 Longpoint I	Road		10f. Zip Code	21222		10g. Citizen of V United		
de Ga	11. Marital Status	12. Was Decedent Armed Forces		13. Was Decedent of	Hispanic Origin	7 (Specify Yes or November 17 (Specify Yes or November 19)		a - Americ	can Indian,
by by	1 Never Married 2€ Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1□Yes 2ĂNo			Specify		White
- 2	15. Decedent's E (Specify only highest gi	rade completed)	16a. [Decedent's Usual Occu Give kind of work don- life. DO NOT use retin	upation a during most o ad)	f working	16b. Kind of Bi	usin ess/I n	dustry
iene.	Elementary/Secondary (0-12)	College (1-4or 2 Years	5+)	cessing Te			Medic	al La	aboratory
be filed tal Hygid d other event, to	17. Father's Name (First, Middle, Las		111	20002119 1		Name (First, Middle	e, Maiden Suman	10)	
Mental Hygarked otheratic event,	Richard J. Mae	eby, Sr.			Do	rothy Sad	ofsky		
& DEE	19a. Informant's Name/Relationship		196.	Mailing Addresa (Stree	et and Number	or Rural Route Num	ber, City or Town,	State, Zip	Code)
th a 27 is trait	Mrs. Louella M	. Maeby (Wi	fe)	3220 Longpe	oint Ro	ad Dunda	lk, Mary	land	21222
ages 1. ant of He t: If Nam y or othy	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci		cemetery	Disposition (Name of crematory or other pl	10.1	Date /1/2000	20c. Location -		
of the same	21. Signature # Fineral Service Lice		HIIICO	22. Name and Add		/1/2000	1000011	, , , ,	- J - Wild
Dep Impo	1 Dregon	E Ken	L	Duda-Ruc	k Funer	al Home of			nc. 1222
Physician	23a. Part I. Enter the dispase, or cor shock, or heart tallere. List and	plications that cause one cause on each I	d the death. Do no ine.						Approximate Interval Between Onset and Death
/Medical	Immediate Cause (Fina)	Oc.	1 mi	0 0	2.0	- A		1	minute.
Examiner	disease or condition resulting in death) a. Ulle Mystardial rufaret Due to (of s a consequence of):								7. dines
je je		Con							
executed in and ial-transit	Sequentially list conditions	b. COYO	Due to (or as a co	onsequence of):	are				
an ar inial-t	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	A 80 W	200	to al	0 11.1	~			
certificate be executed ding physician and use as the burial-transit	that initiated events reaulting in death) Last	BU BYBIRS							777
ding ph se as t	Touching in doubly East	Enn.	den					1	
r use		d.	vivien	V					
death ed for	Part II. Other eignificant conditions	contributing to death t	out not resulting In	the underlying cause g	iven in Part I.	23b. Di	d tobacco uae çe	ntribute t	o the cause of death:
es that the death of gned by the attento be detached for until by Physician	Dialeta	melletu	-			10	Yes 2 No	3 □ Pro	bably 4 Unknow
requires that the death of been signed by the atten should be detached for u letted by Physician	Kanalin	Melletu					is an autopsy tormed?	av	/ere autopsy findings vailable prior to empletion of ceuse
has pe 2	Severe Oli	outy.				10	Yes 2 No		death?
certificate irector, pag	25. Was cese referred to medical	0			26. Place o	f Death (Check only	r one)		
Physicien: this certific ral director,	examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Out	patient 32 DOA	ther: 4 Nurs	ing Home 5 Re	sidence 6 Oth	ner (Speci	(h)
Attending Pt r death. ector: After th by the funeral	27. Mannerof Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, De	ury 28b. Ti	jury W	uryat ork? ⊒Yes 2 □ No		e how injury occur	red	
Pri in Pri	3 Suicide 6 Could not determined	of be on Plan of Lain Albana and Araba office 29t Location (Street and Number or Rural Route Number						al Route Number,	
To the Hospital Within 24 hours to To the Funerel I completely filled Medical Co	(Check only 2 Medical Exa	miner: On the basis of	of examination and	death occurred at the or investigation, in my					
the thin 2 the Raplet	one)	and manner s	tated.	200 1 100	nse number		29d. Date signe	d (Month	Day Year)
T V V	29b. Signature and title of certifier	1/91	10			Q1			
0	Molly	holy	- /VI-	D. D.	00021	71	7	, 30	,4000
7	30. Name and address of person who	GOLPIK		ype, Print) 29 Dune	lalk	ane Ba	ltimae	MI	21222
State	31. Date filed (Month, Day, Year) MAY 3 1 20	nn 32. Regist	rar's Signature	. Spork	2				

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Dichela melletis Republicationic Teren Obertz

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1 MD. 302

\$86.2 E & YAL

00-2878-510 Donald McClain JVW

DHMH 16 Rev 6/95

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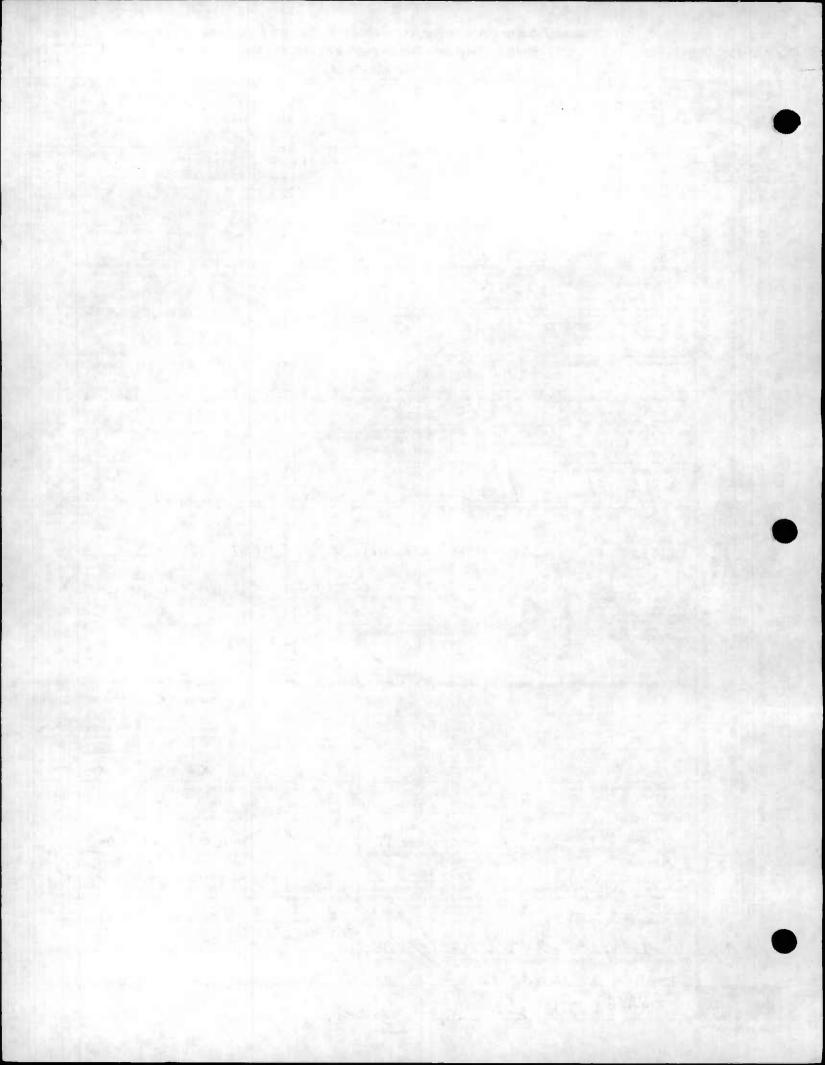
State of Maryland / Department of Health and Mental Hygiene

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√W				Ce	ertificate d	of Death		Reg. No.				
	1. Decedent's Name (First, M	iddle, Last)					2. Date of De		Van	3. Time of Death		
Physicia: "/Medica	Y YM (L L ALVIC X L	LAIN					Month May	24,200	O Year	03:37A.M.		
Examine	de Englis, blome /// and books		number)				, or Location of Deat	h 4c. Count	ty of Death			
Funeral	5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday	if Under 1 Y			rth		place (State or Foreign		
Director	177-58-5567 Usuai Residence of Deceden	1 M 2 □ F	35	Yrs.	Months Da	ays Hours	Min. (Month, Di			SYLVANIA		
ahow ahow	10a. Stete 10b. Cos	inty	10c. 0	City, Town or L	ocation.				1	IOd. Inside City Limits		
the Man	MD 10e. Street and Number	N/A		BALTIM	ORE CIT			10g. Citizen of	What Cou	1 X Yes 2 □ No		
The state of					101. 21p CO	26		TOG. CRIZETI O	What Cour	nity?		
72 hours after daeth with the Maryland natural", or freme 23s or 23s-f show dical Examiner must be notified at	2530 N.W. EDG 11. Marital Status 1 X Never Merried 2 1	12. Wes De Armed	CLE ecedent Ever in Forces? s 2 X No	U,S. 13	Was Decedent if Yes, specify	215 of Hispenic Origin Cuben, Mexicen, F	o? (Specify Yes or No Puerto Rican, etc.)	USA 14. Ra Bia	A aca - Americ ack, White,			
irs a	3 ☐ Widowed 4 ☐ Divor	If Yes (Give	2000	1 ☐ Yes 2 🔀	No Specify:		Speci	ly: BI	ACK		
natural',		dent's Education		16a. Dec	edent's Usuai O	ccupation		16b. Kind of E				
5 .	(Specify only hi	phest grade complete		(Giv	B kind of work do DO NOT use re	one during most of	f working					
filed within 72 hours af Hygiena. ther than "netural", or ont, it a M. vical Emeri	Elementary/Secondary (0-1	2) College	(1-4or 5+)	T.AP	ORER			CONSTRU	TOTTO	N .		
	17. Father's Name (First, Mid	die, Last)				18. Mother's	Name (First, Middle					
d 2 should be filed in and Mental Hygi raumatic event,	EDWARD BLOUN	T				MARY	MCCLAIN					
d 2 should the and Men 7 la marke traumatic	19a. informant's Neme/Relet	onship (Type, Print)		19b. Mai	ing Address (St	reet and Number of	or Rurel Route Numb	er, City or Town	n, State, Zir.	Code)		
CENL	MARY MCCLAIN		MOTHER	234	1 N. 25	th ST. P	HILADELPH:	TA, PA.	1913	32		
s 1 and of Haalth Hem 27 other tr	20a. Method of Disposition			Place of Disp	osition (Name o	1	Date	20c. Location		-		
age or F. F.	1 N Buriai 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	(Specify)		r. PEAC	E CEMET		6/1/2000	PHILAI	DELPH:	IA, PA		
permit. Pa Departmen Important: any injury	21. Signature of Funerei Sen	ice Licensee	RAL HOME,	P.A.								
	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lide.									286		
	shock, or heart failure.	, or complication≰ tha List only one cause or	t caused the de each lide.	ath. Do not er	nter the mode of	dying, such as ca	rdiac or respiratory a	rrest,	1	Approximate Interval Between Onset and Deeth		
Physician	/									Onset and Deeth		
/Medical Examiner	Immediate Cause (Finei disease or condition	. Gu	nshot	W/01	und	of c	nest					
		Due to (or as a consequence of):										
P = 5		- 5										
certificate be executed ding physician and ise as the bunal-transit	Sequentially list conditions,		Due to	(or as e conse	equenca of):							
e exe												
ficate be experience of the purial as the burial	that initiated events resulting in death) Last		Due to	(or as e conse	quence of):							
E 0 6	Cause (Disease or injury that initiated events resulting in death) Last											
	2	0										
es that the death or gned by the attention be detached for u	Part II. Other significant cond	fitions contributing to	death but not re	esulting in the	underlying caus	given in Part i.	23b. Dld	tobacco use co	ontribute t	o the cause of death?		
at the datache	È						10	Yes 2 No	3 Pro	bably 4 Unknown		
£ X 0												
		-18/11						s an autopsy ormed?	av co	ere autopsy findings reilable prior to propietion of cause death?		
The law ate has page 2	5						100	Yes 2□No	16	Yes 2□ No		
dollan: The cartificate rector, pa		licai				26 Place of	Death (Check only					
Physician: rthis cartific inal director.	NO XXX Sec 20 No	Hospital:	inpatient 2	□ EX/Outpatie	ent 3 DOA	Other:	ing Home 5 Resi		ther (Casei	64)		
Phy aralog and phy		28a. Dat	e of Injury onth, Day Year)	28b. Time		Injury at Work?		how injury occu		197		
Attending Ph ir death. ector; After th by the funeral	1 □ Naturai 5 □ Pe	Work? 1 ☐ Yes 2 2X No	c.h.			4						
l or Attending after death. Director: After d in by the fune	2 Accident investigation 5 - 24 - 2000 un mount 1 Yes 2 18 No 28e. Place of injury. At home, farm, street, factory, offica							C+ was	ber or Ruri	al Route Number.		
- 2	4 Homicide det	City or To	wn, State) 5 2	00 Bloc	ek Vinginia							
Hospital 24 hours Funeral Italy filled	29a. Certifier 1□ Certi											
To the Hospital or within 24 hours aff for the Funeral Discompletaly filled in Medical Co.	(Check only one)	cal Examiner: On the	ne best of my Kr basis of examir inner stated.	nation and/or i	nvestigation, in r	ny opinion, death	occurred at the time,	, date and placa	, and due t	o the cause(s)		
of the complete of the complet	E 29b. Signature and title of cer				29c. Lie	cense number		29d. Date sign	ed (Month.	Day, Year)		
F 3 E 3	290. Signature and title of certifier O.C.M.E.							May 24				
11/	Alys	101	lac	19,	np			-				
MIL	30. Name and address of pers	Λ .		em 26a) (Type	, Print)							
	Stephen S.	Rader	7		111 Per	nn Street	t, Baltimo	ore, Mar	yland	21201		
State	M/AV 2 1	9ar) 32.	Registrár's Sign	neture	1			1				
Registrar		000		D	BOOK	1						

ORIGINAL

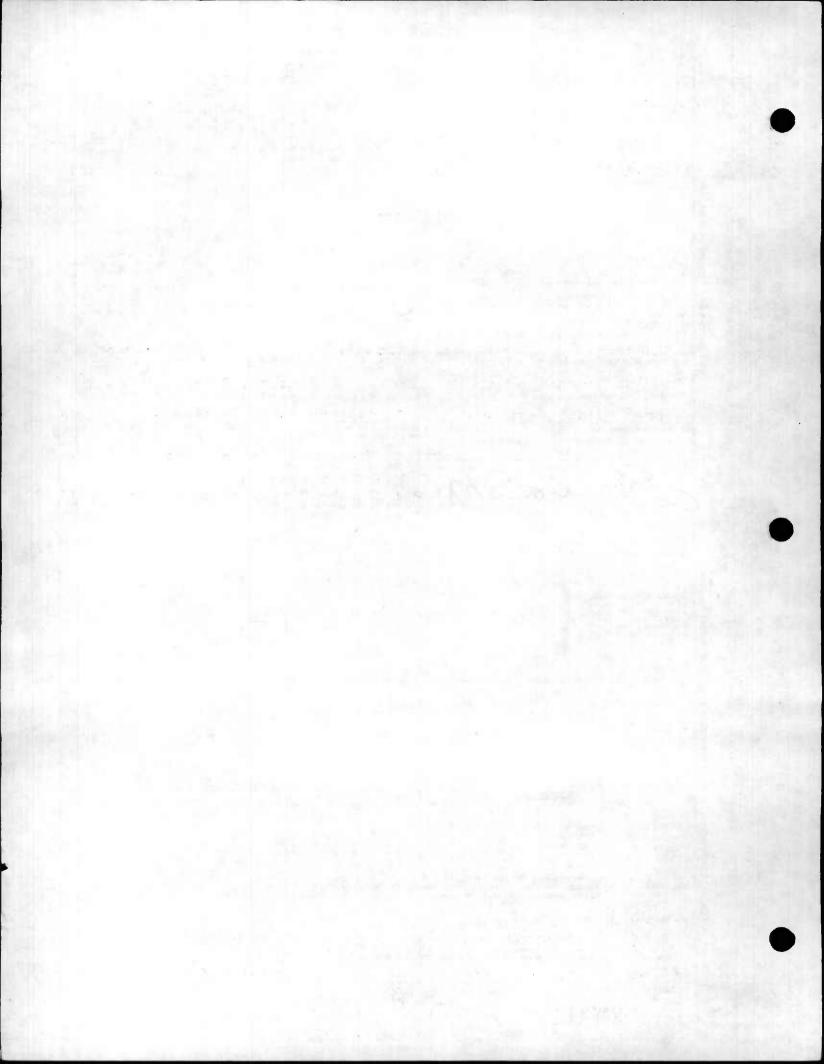


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Dorothy 4a Facility Name (If not institution, give street and number) Nunnally May 4b. City, Town, or Location of Death 9:51pm 25 2000 /Medical Mae 4c. County of Death Examiner Gilchrist Nursing Home Baltimore Co. If Under 1 Yeer Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 M 2 K F Months Days Hours Yrs. Director 217-22-4602 Usuel Residence of Decedent 09 08 M.D. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits No Yes 2□ No Director MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7410 Allmont Road 21244 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② CNo If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Domestic 6th grade 17. Father's Neme (First, Middle, Last) Private permit. Pages 1 and 2 ahould be fliet Department of Health and Mental Hy Important: If Nem 27 Is marked other eny Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Patrick Bacon Margaret Jones 19e. Informent'a Neme/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Warren Nunnally-Husband 7410 Allmont Road, Baltimore Md 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete YG/Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Vet 5-31-00 Owings Mills, Md ral Service Licensee 22. Neme and Address of Fecility March F/H West 4300 Wabash AVe, Baltimore Md of enter the mode of dying, such as cardiac or respiratory errest, 21215 Pert1. Enter the disease, or complications that caused the death. Do not enter shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Anoxic encephalo Due to (or es a consequence of): Examiner Physician/Medical Examiner renficular fibrill Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760, COVONARY Due to (or es a consequence of Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown end-stage renal disense Records, ð 24b. Were eutopsy findings available prior to completion of cause of death? Completed mellitus 24a. Wes en eutopsy performed? 1 ☐ Yes 3 € No 1 ☐ Yes 2 ☐ No of Vital Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 5/01 C Certification: To 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 1 Netural 5 Pending investigation To the Hospital or Attanding within 24 hours after deeth. To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 ☐ Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier ↑ Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, and due to the cause(s) and menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) may 26, 2000 30. Name and address of person who completed cause of doubt (Item 23a) (Type, Print) Go. Md 21204 0 GBONC

State Registrar 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death AGUWA. ONUH Month Day Year **Physician** CAROLING 10-33AM 17-2000. 05-/Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Regional Laurel Prince aurel George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 9. Birthplaca (State or Foreign **Funeral** . Nigeria 1 M 20XF N/A 4-10-1930 Director Usual Residence of Decedent with the Merylend 10d. Inside City Limits 10a. Stata 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23s or 25s-1 show other trsumstic event, the Modical Examiner must be notified at 1 ☐ Yes 27 No Director Umokeriri N/A Ihitte 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? N/A Nigeria permit. Pages 1 end 2 should be filled within 72 hours efter deeth v Opperment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23, any injury or other traumatic event, I'm Medical Examins must Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: Black altimore, Maryland 21215-0020 1 Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be Awazie Opuha Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aston Onuh/Son 8818 Hunting Lane #202, Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Melhod of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 6/10/00 Umokeriri Ihitte of Funeral Service Lice 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Cardiac Amylhmig Immediate Cause (Final disease or condition resulting in death) /Medical 30-45 mmts Examiner Due to (or as a consequence of) Physician/Medical Examiner Hy pertension The lew requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end P.O. Box 68760, Due to (or as a consequenca of) ettending i Tem 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause 236. Did tobacco use contributa to the cause of death? been signed by the should be detached 3 Probably DVT. Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed After this certificate hes 2 0 No 1 ☐ Yes 2 No t[] Yes Hospital or Attending Physician: director, 25. Was case refarred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 No 1 inpatient funeral 28c. Injury at Work? 27. Maryner of Deal 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident efter death Director: 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homiclde To the Hospital or within 24 hours eft To the Funeral Discompletely filled in edicai 1 🖄 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier DHENDING D 42580 5-18-2000 Aug MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

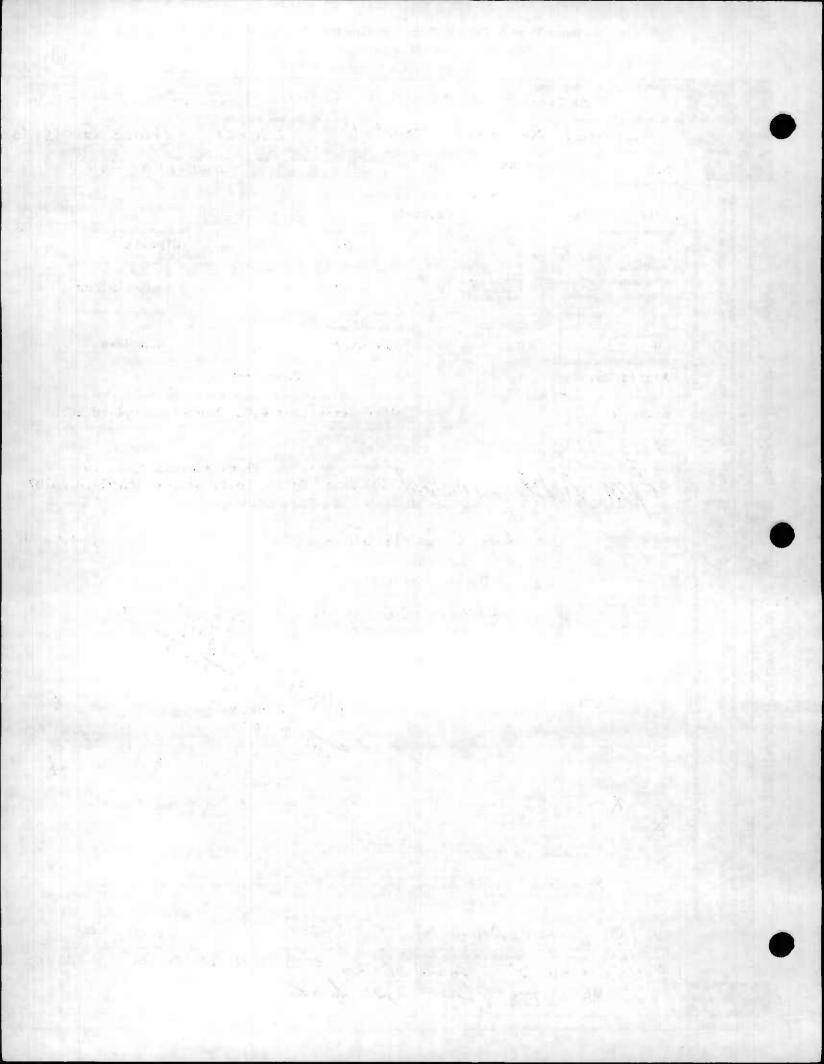
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32. Registrar's Signature

Annapolis Rd #13 BLADENSBURG MD-20710.

State Registrar

Q



giene

17182

10d. Inside City Limits

Approximete Intervel Between Onset and Death

 Wera autopsy findings available prior to completion of cause of death?

1 Yes 2□ No

MAY 29, 2000

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

14. Raca - American Indian,

White

Black, White, etc.

U.S.A.

1 Yes 2 No

01111111						State	of Ma	arvianc	/ Department	of Health	and M	lental Hy
AMEND	ITEMS:	#23	PART	I,	27	PER	MEO	G784	6-Certificate	of Death	7	

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Detes:

College (1-4or 5+)

TI	IIIO. #25 TART I	, Z/ EER I	TEO G704 0-Cel	rtificate	of	Death		Reg	J. No.			
cian	1. Decedent's Neme (First, Mid							2. Date of Death Month	Day	Year	3. Time of	
lical	John Thomas 0:	Lear, Jr.						MAY	28	2000	6:32	PM
iner	4a Facility Name (If not instituti	ion, give street and nu			4b. City, Town,	or L	ocation of Death	4c. Coun				
	NORTHWEST HOSE	PITAL CENTI	ER			RANDAL	LS	NWOT	BA	LTIMOF	E	
l r	5. Social Security Number 220-72-3864	6. Sex 1 M 2 □ F	7. Age (In yrs. lest birthdey) 38 Yrs.	Months (Yeer	Hours A	lin.	8. Dete of Birth (Month, Dey,) March 7,	rear) 1962	9. Birthp Coun Mary		r Foreign
-	Usual Residence of Decedent										- 11	

10f. Zlp Code

21207

1 Yes 2√ No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.)

10c. City, Town or Location

Woodlawn

Funera Directo

10a. State

10a Street and Number

11. Meritel Stelus

10b. County

2213 Maple Hill Court

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

Baltimore

15. Decedent's Education (Specify only highest grade completed)

Physi /Med Exam

with the Meryland Show 28a-1 items 23s or 6

Directo

þ

filed within 72 hours efter Hygiene. Mental

other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be

Maryland 21215-0020

Baltimore,

Department of Health and Mental Important: If item 27 is marked any injury or other traumetic ev

Physician

/Medical

Examiner The law requires that the death certificate be executed and bunal-tre Box 68760. physician the USe as ò P.0. signed by t of Vital Records, cate has been significant page 2 should b certificate has this funeral After t Division s after de-al Director: Atte filled in by

Completed Student-Special Education Never worked n/a 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be John Thomas Olear, Sr. Helen Hedwig Varhach 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Thomas Olear, Sr.-Father 2213 Maple Hill Court, Woodlawn, Maryland 21207 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 6/2/00 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart leiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPERTROPHIC CARDIOMYOPATHY Due to (or es a consequenca of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Last Due to (or as a consequenca of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1XYes 2□ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Netural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - Al home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifies 29c. License number

DHMH 16 Rev 6/95

State Registrar

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To the Hospital within 24 hours a To the Funeral Completely filled Hospital 24 hours a

30. Neme and address of person

31. Date filed (Month, Day, Year)
MAY 3 1 2000

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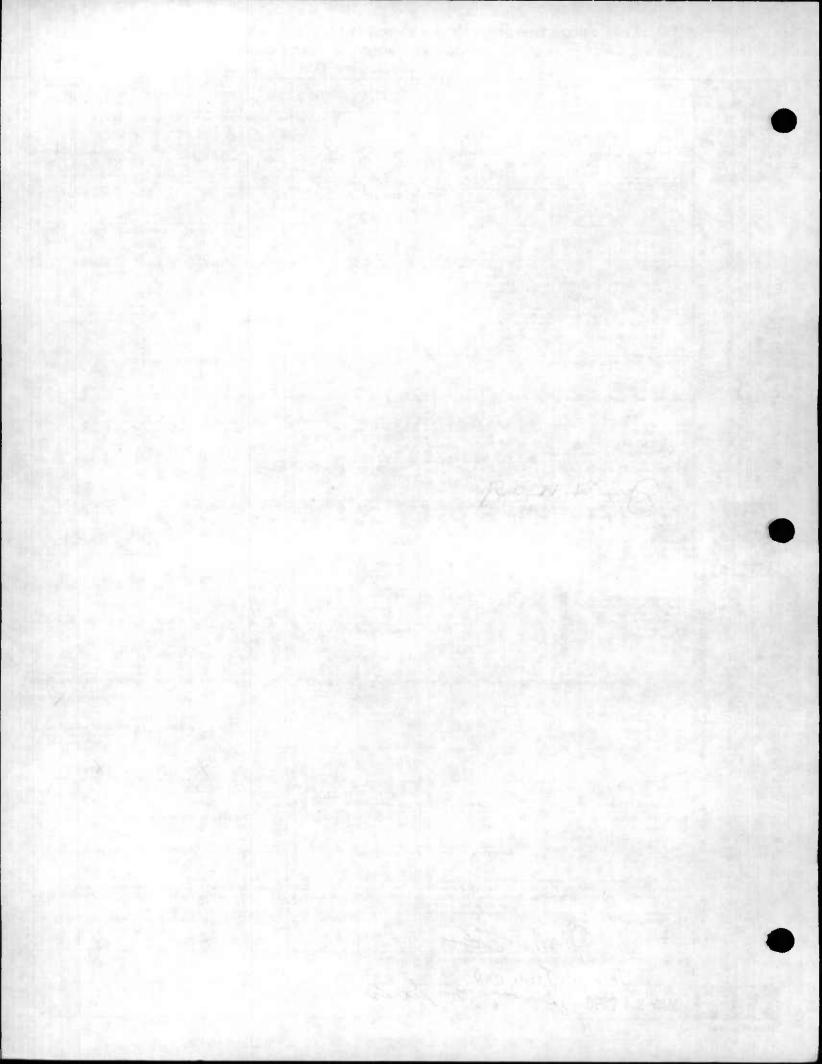
who completed cause of death (Item 23a) (Type, Print)

32 Registrare Signature

MiD

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Year Month **Physician** Mary Kate Page 2000 4b. City, Town, or Location of Death 29, 1:50pm /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 35th Street Baltimore 1311 East NA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 08-22-22 Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Vrs VA Director 231-24-2423 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director VA NA Radford 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 8 Willow Wood Apt. #69 238 24241 USA Funeral Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specity: p Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4th Grade NA Domestic work in home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Daniel Black Elnora Black 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Relationship (Type, Print) Tommy Page 1326 Homestead Street Baltimore, Maryland lepartment of Health mportant: If Item 27 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ty Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) New River Cemetery 06-03-2000 New River, VA 22. Name and Address of Fecility Baltimore, Maryland 21202 21. Signeture of Funeral Service Licenses WM.C.March FH 1101 E. North Avenue Approximate Interval Between Onset and Deeth 23a. Part1. Enter the diseese, or complications that ceused the shock, or heart feilure. List only one cause on each line. Do not enter the mode of dying, such as cerdiac or respiratory arrest, **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated successions) Due to (or as e consequence of): Physician/Medical phys. that initiated events resulting in death) Last Due to (or as a consequence of): 080 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part 1. 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To After this 28b. Time of Injury 27. Manger of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death Director: 28f. Location (Street and Number or Rurel Route Number, City or Town, Stele) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours The Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

DHMH 16 Rev 6/95

To the To the

death.

Hospital

altimore, Maryland 21215-0020

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Pages 1 and 2 should be nent of Health and Mental

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital Physician:

Division or Attending

> State Registrar

MAY 31

Surkara

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

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29b. Signature and title of certific

31. Dete filed (Month, Dev. Year)

32. Registrar's Signa

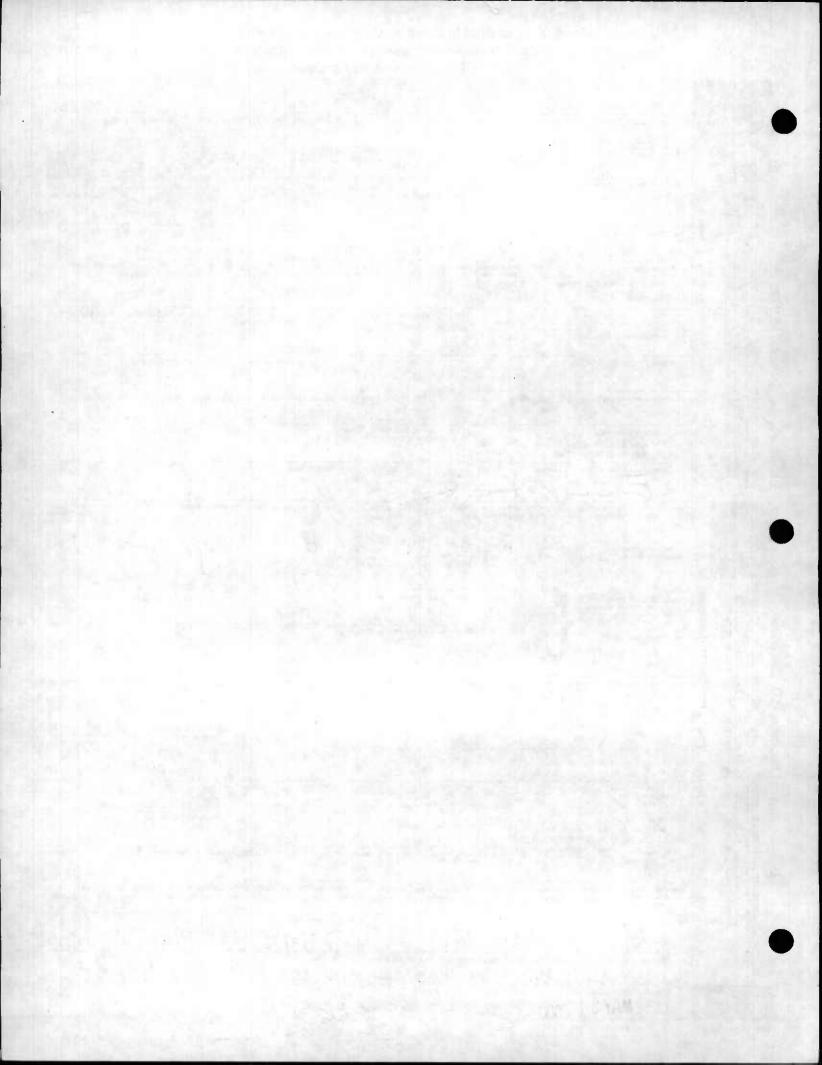
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ORIGINAL

29c. License number

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29d. Dete signed (Month, Dev. Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Neme (First, Middla, Last) 3. Tima of Death Month Yaar 4.30 P.M. HUBELT PARKER MAY 22 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE H Undar 24 Hrs. 8. Data (Mont HARBOR HOSPITAL If Under 1 Yaar 5. Social Security Number Birthplaca (Stete or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) Days 12M 20 F Months 213-36-2661 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 483 2 No BALLIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedant Evar in U,S. Armad Forcas? 1 ☑ Yas 2 ☐ No If Yas, Giva USA 2656 Race - American Indian, Black, Whita, etc. Was Decadent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Nevar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: BL MC/C Specify. 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) SELF EMPLOXE 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) ARKER FRANCIS 1-100 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) MATTHELL 20b. Placa of Disposition (Nama of camatary, cramatory or other placa, 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State ZIONI -1-00 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility How ELC 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as carefac or respiratory arrest shock, or heart tellure. List only one cause on each line. Approximate Interval Between Onsat and Death ASPIRATION ENCEPHALOPATHY 6 days AMONIC Due to (or es a consequence of): MA Known of oral Dua to (or as a consequance of):

Physician /Medical Examiner

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the attending physician

Physician

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tism 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinal must be nothed at

I Hygiene.

Department of Health and Mental Hygion reportant if itsm 27 is marked other

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0020

Immediate Ceuse (Final disaasa or condition rasulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying

Cause (Disaase or injury that initiated avents resulting in death) Last	cDua to (or as a consequence of	():		
Part II. Other significant conditions		sulting in the underlying	g causa givan in Part I.	23b. Did tobacco use co	ntribute to the cause of death
'SGIZURE 1	230-205 IC				
AMBAMA.				24e. Wes en eutopsy performed?	24b. Were autopsy tindings available prior to completion of cause of deeth?
				1 ☐ Yas 2 🗷 No	1 ☐ Yes 2 ☐ No
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axaminar? 1 ☐ Yas 2 🔁 No	Hospitel: 1 Inpatiant 2	☐ ER/Outpatient 3☐ I	DOA Other: 4 Nursing	Homa 5 ☐ Rasidance 6 ☐ Ott	nar (Specify)
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3 ☐ Suicide 6 ☐ Could not 6 4 ☐ Homicide determined		noma, farm, street, fact	ory, offica	281. Location (Street and Numi City or Town, Stata)	bar or Rural Routa Number,
				e, and due to the cause(s) and mourred at the time, date end plece,	

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

State Registrar

RANDEEP 31. Data filed (Month, Day, Year) MAY 31

29b. Signature and title of certifiar

30. Nema and addrass of person who completed causa of daath (Itam 23a) (Type, Print) CAUTHO 32. Registrar's Signetura

M.D.

29c. Licansa number

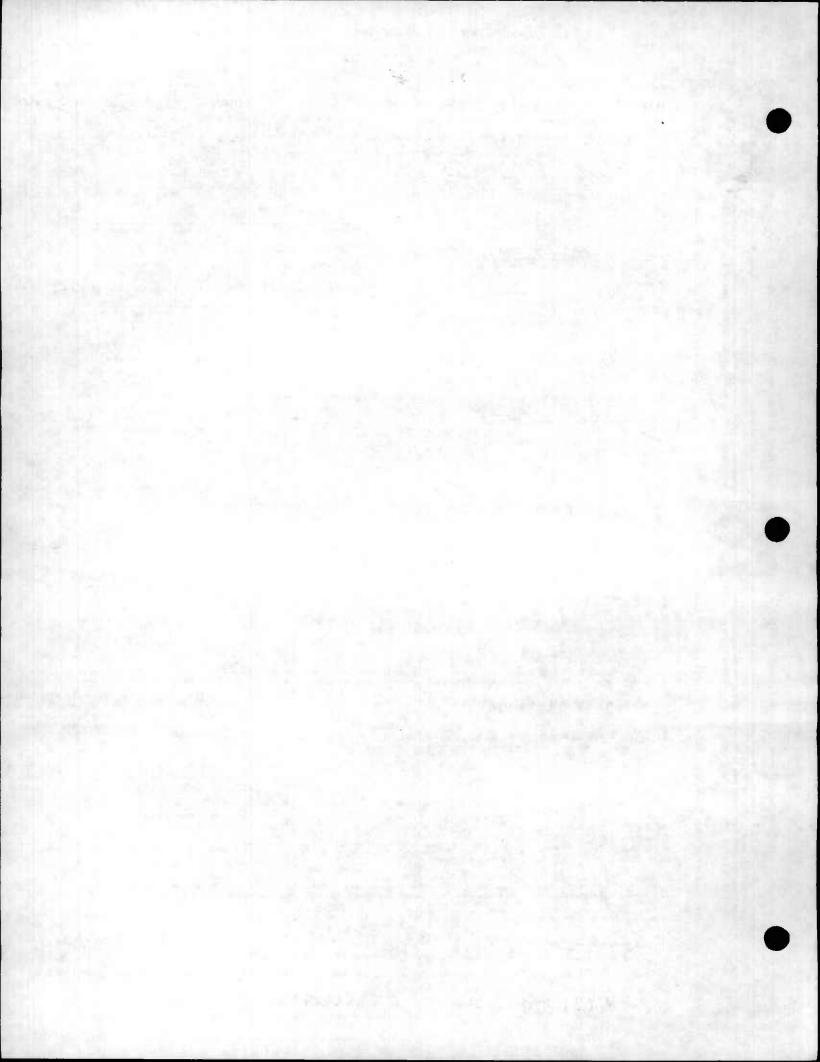
Monistal

29d. Data signed (Month, Day, Year)

Ballimore, mo

2000

7774 . .



State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 12:25 pm . J. SAEZ - PORTO CARRERO CARLOS PAPE 2000 30 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner VETERANT ADMINISTRATION HOSPITAL BALTIMORE BALTIMERE COUNTY H Under 1 Yeer H Under 24 Hrs. Months Days Hours Min. Min. May 4, 1943 5. Social Security Number 6. Sex 1 M 2 F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Puerto Rico Yrs. 57 Director 580-80-8634 Usual Residence of Decedent 10a. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD Baltimore or 28s-f Reisterstown 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? 238 247 Highmeadow Road 21136 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes, 2 □ No 1962 – 1 Yes, Give Year or Dates: 1971 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Biack, White, etc. filed within 72 hours after 1 Never Married 2 Merried 1 Yas 2 □ No Specify: b 21215-0020 al Hygiens. I other than "natural", or want, the Medical Exen-Specify: Spanish 3 ☐ Widowed 4 ☐ Divorced Puerto Rican Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Dispatcher Genstar Maryland 17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be the ment of Health and Mental H tant: If them 27 is marked oth dury or other traumatic even Be Jose В. Saez Portocarrero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean P. Saez 247 Highmeadow Road, Reisterstown, MD 21136 Saltimore, important of important if its any injury or ott gags. 20a. Melhod of Disposition 20b. Placa of Disposition (Name of cemetary, crematory or other placa) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from Stala Pine Grove Cemetery 6/2/00 4 ☐ Donation 5 ☐ Other (Specify) Rayville, MD 21. Signature of Fuperal Service Licenses 22. Name and Addrass of Facility 11824 Reisterstown Road kien ia ow Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onsel and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical 13 1095 PHERMONIA Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initialed events rasulting in death) Last and Due to (or as a consequence of): burial-trer Box 68760. physician Physician/Medical the Due to (or as a consequence of): USB AS P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 ☐ Unknown ACUTE RENAL FAILURE Division of Vital Records. P been significant 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? INSMILIN DEPENDENT DIAGETER MILLETILL completion of causa of death? ACUTE certificate RESPIRATORY DISTROSS SYNDROWE . 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to 25. Was case referred to medical Be 26. Placa of Death (Check only ona) examinar? Hospital: Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 ☐ Nursing Homa 5 ☐ Rasidenca 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledga, daath occurred at the time, data and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 813403 MD MAY 30 , 2000 30. Nama and address of person who completed cause of daeth (Item 23a) (Type, Print) CHUKWUMA . O. ONYEWY, MO 10 NORTH GREENS St. BALTIMORE, NO ZIZOI

Registrar

31. Dele filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Deeth May 26, 2000 **Physician** Cynthia Ellen Powers 11:15P.M. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 715 211th Street Pasadena Anne Arundel Hunder 24 Hrs. 8. Dete of Birth March Day, Year) 1920 9. Birthplace (Stere or Country) Tennessee 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Days 10 M 2 F 219-22-2100 80 Yrs. Director **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD. Anne Arundel Pasadena 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 715 211th Street Nems 23s 21122 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within College (1-4or 5+) N/A Elementery/Secondary (0-12) 8th Grade Seamstress Sewing Factory parmit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If Item 27 is marked other any Injury or other traumatic event area. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Garrett Baird Adelett Bolten 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Estle Powers Husband 715 211th St. Pasadena, MD. 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 ☐ Cremetion 3 ☐ Removel Irom State Glen Haven Mem. Park 5/30/00 Glen Burnie, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Lig 22. Nama and Address of Facility McCully-Polyniak Funeral Home, PA 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter me mode of dying, such as caldiac or respiratory areas. MD. shock, or heart trillure. List only one cause on each line. 21122 **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es, a consequence of): Physician/Medical Examiner aun Mull sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated asserts. Due to (or as a consequence of): physician s the buria Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): pertusius Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown sate has been signed page 2 should be det þ Completed 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy performed? completion of causa of deeth? 1 Yes 2 No 1 Yas 2 No certificate director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

P.O. I Records, Division of Vital

or Attending Physician: this funeral After death. 24 hours after deal Funeral Director: in by completely filled Hospital within 2 To the

Registrar

1 Neturel

2 Accident

3 Suicide

29a. Certifier

Antonia

MATA Pate filed (Month, D

edical

4 Homicide

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

DHMH 16 Rev 6/95

of person who completed cause of death (Item 23a) (Type, Print)

Arnold, md 21012

28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify)

Kitchie 509

32. Registrar's Signatura

aports.

1 Yes 2 No

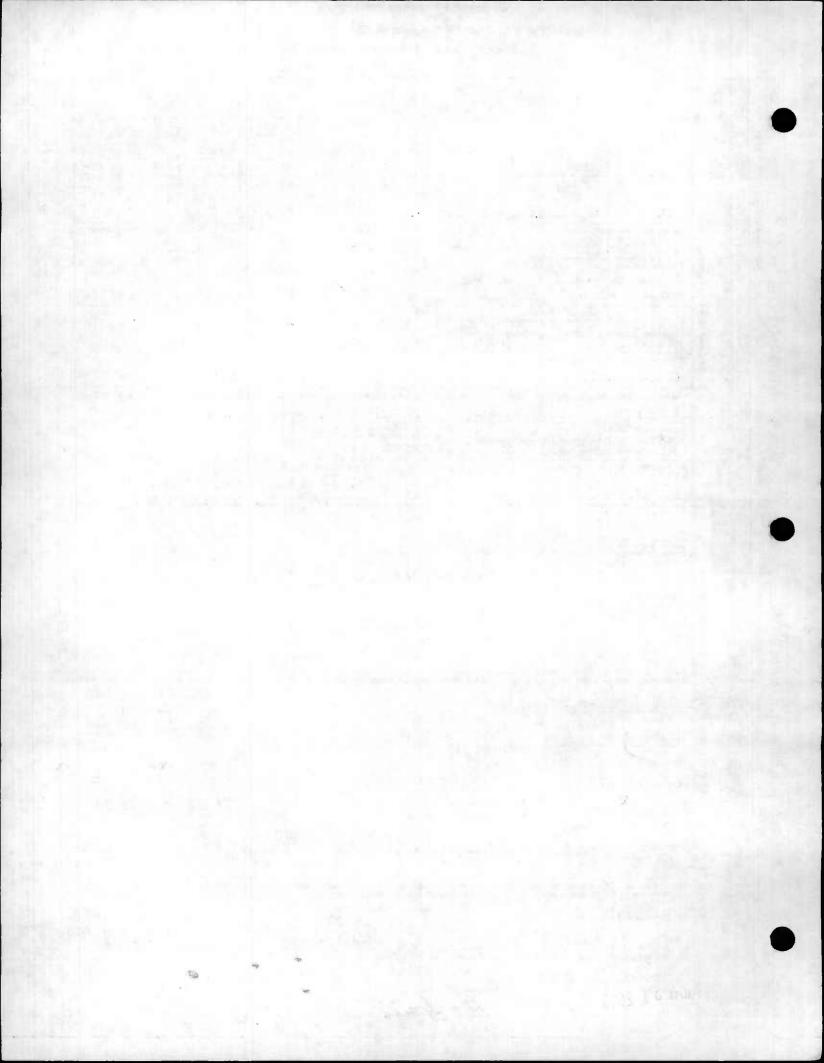
Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29c. License number

28I. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 30100



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17187

nysician	1.1	Decedant's Nama ((First, Middla, La	st)						2. Data of De			3. Time of Death
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by Funeral Director		Marital Status 1 Navar Married 3 Widowed 4		12. Wes Deceder Armed Forca 1 Yes 2 If Yes, Giva Year or Dete	s? XNo		Vas Decede Yes, speci Yes 2			Specify Yes or No to Rican, etc.)	Specify	a - America k, Whita, a	
Completed		/Specific	5. Decedent's Ed	fucation		16a. Decede	ant's Usuai	Occupat	tion	adrina	16b. Kind of Bu	usinass/Ind	lustry
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		a. Informant's Nam			, ,						per, City or Town,	Stete, Zip	Code)
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State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thelma Kane Pfeiffer 2000 2:55PM May /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore Stella Maris Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 11, 1912 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F 216-01-0476 88 Yrs. Director Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Towson 1 Yes 2 No Maryland Baltimore Directo 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21286 United States 7925 York Rd. 230 Funera 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Merried 2 Married b 1 ☐ Yes 2 No Specify: Specify: white 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Maryland 1 and 2 should be fill lealth and Mental H im 27 is marked off Be Frank Kane Shriver Mary Aurelia 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is: any Injury or other trau abse. Timonium, MD 21093 Susan Pfeiffer-Wetzel/daughter 19 Tenby Ct. Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) unt Crematory 5/27/00 Baltimore, Maryland
22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Greenmount Crematory 21. Signeture of Funeral Service Licensee 6500 York Rd Baltimore, Maryland 21212 PM-1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, nock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediete Ceuse (Final disease or condition resulting in death) /Medical Cerebrovascular Accident Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hnknown ğ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy The law 1 ☐ Yes 2 V No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence MOther (Specify) Hospice 2 1 Yes 2 No 2 ER/Outpatient 3 □ DOA to SH4 28c. Injury et Work? 27, Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Affec Division 1 X Natural 2 ☐ Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Euceral Director: After Completely lifed in by the fun 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) B 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner es stated.

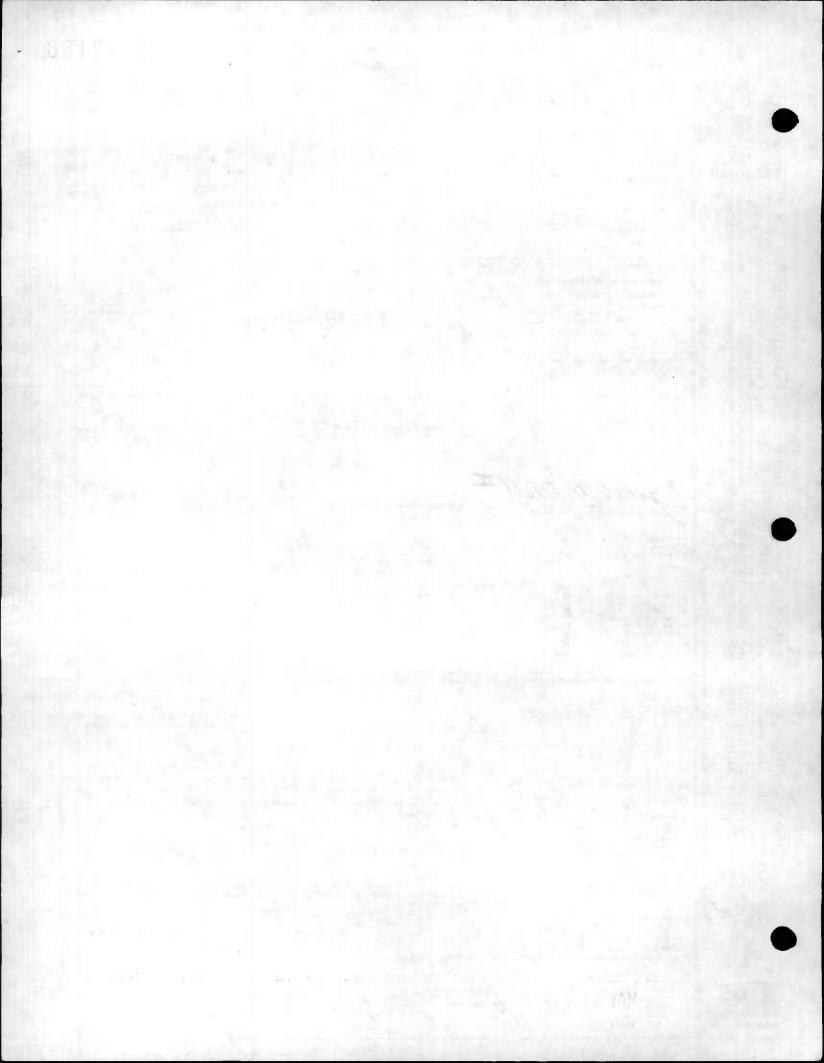
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093 31. Date filed (Month, Day, Year) MAY 3 1 2000 32. Registrar's Signeture State Registrar

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2000

25,

Thelma Pfeiffer



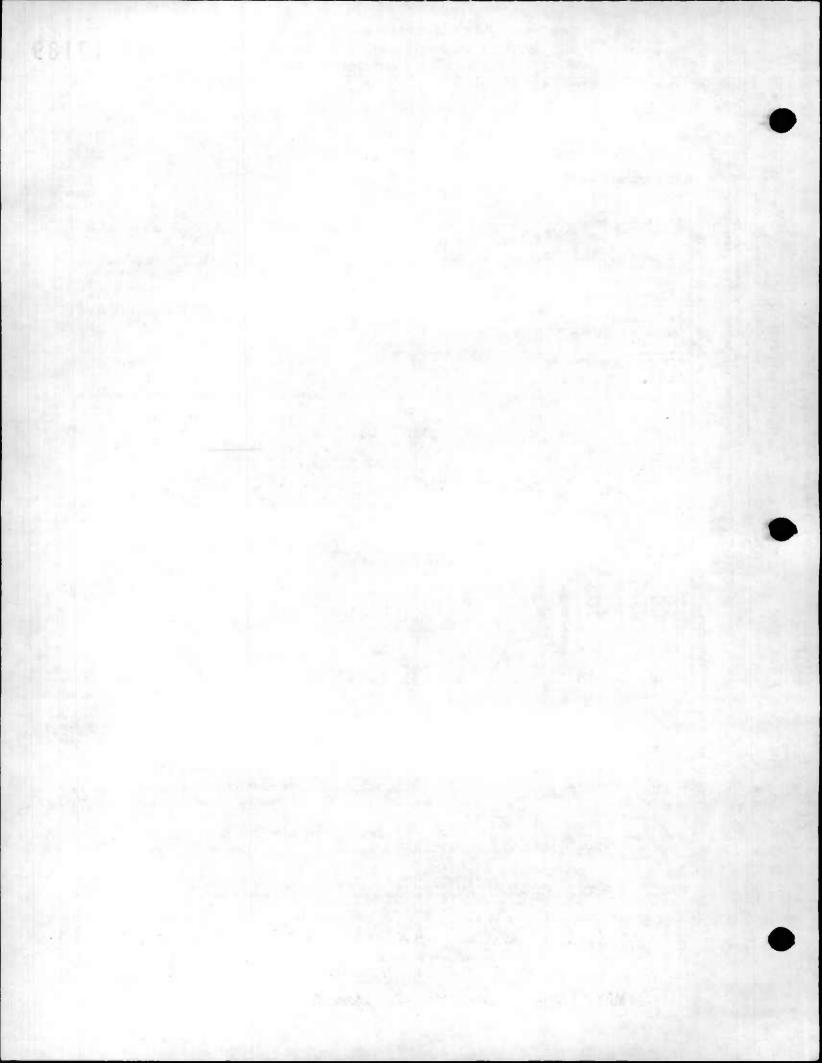
State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #20b PER FH G784 6/5/2000 AH Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month 3. Time of Death **Physician** ALBERT May 27, ROCKEL 2000 9:35 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Hospice of Baltimore, Gilchrist Center Baltimore Baltimore If Under 1 Yaar | If Undar 24 Hrs. Birthplaca (Stata or Foreign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) June 18, 1918 7. Aga (In yrs. last birthday) **Funeral** Days 10X M 20 F Yrs 220-18-5995 Director Md. Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☒ No Director Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1215 Oak Croft Dr. 21093 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ঐ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indian. Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married Maryland 21215-0020 1 Yas 2 No Specify: Specify: à 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Self Employed Business Owner 17. Father's Nama (First, Middle, Last) 18. Molhar's Nama (First, Middle, Maiden Surnama) Be and 2 should be in a saith and Mentel Harry HENRY Rocke1 Loretta Trainor 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H Mr. Eric G. Rockel/son 1610 Riderwood Dr. Lutherville, Md. 21093 Baltimore, permit. Pages 1 a Department of He Important: If Nem any injury or other 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata /2000 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Jessop Church Cemetery Sparks, Md. 22 Name and Addrass of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Rd. Towson, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset end Death 6 **Physician** Acerebral Hemorrhage Immediata Causa (Finel disaesa or condition rasulting In death) /Medical 2 weeks 5 Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiata cause. Entar Undarfying Cause (Disaasa or Injury Ihat Initiated avants resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 1 Yes 3 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yes 2 ☐ No Attending Physicien: ROCKS 25. Was case reterred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospice 1 Yas 2 No Certification: To this 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending Invastigation 1 Yas 2 No 2 Accidant after death 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) in by 4 Homicida 6 24 hours a Medical 29a. Certifier Certifying Physician: To tha best of my knowledga, death occurred at the time, date end place, end due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and manner stated. To the Vithin 2 29c. License number 29d. Data signed (Month, Day, Year) corp 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 2120x 16-BMC 6701 32. Registrer's Signatura 2000 Registrar

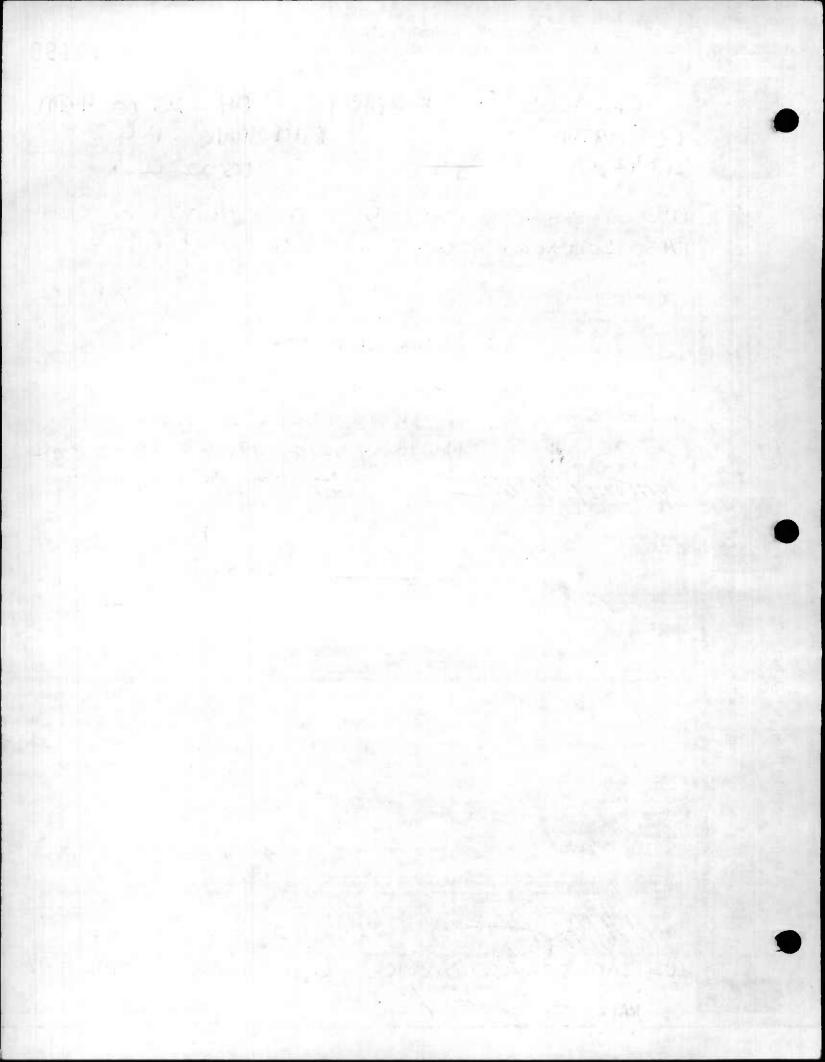
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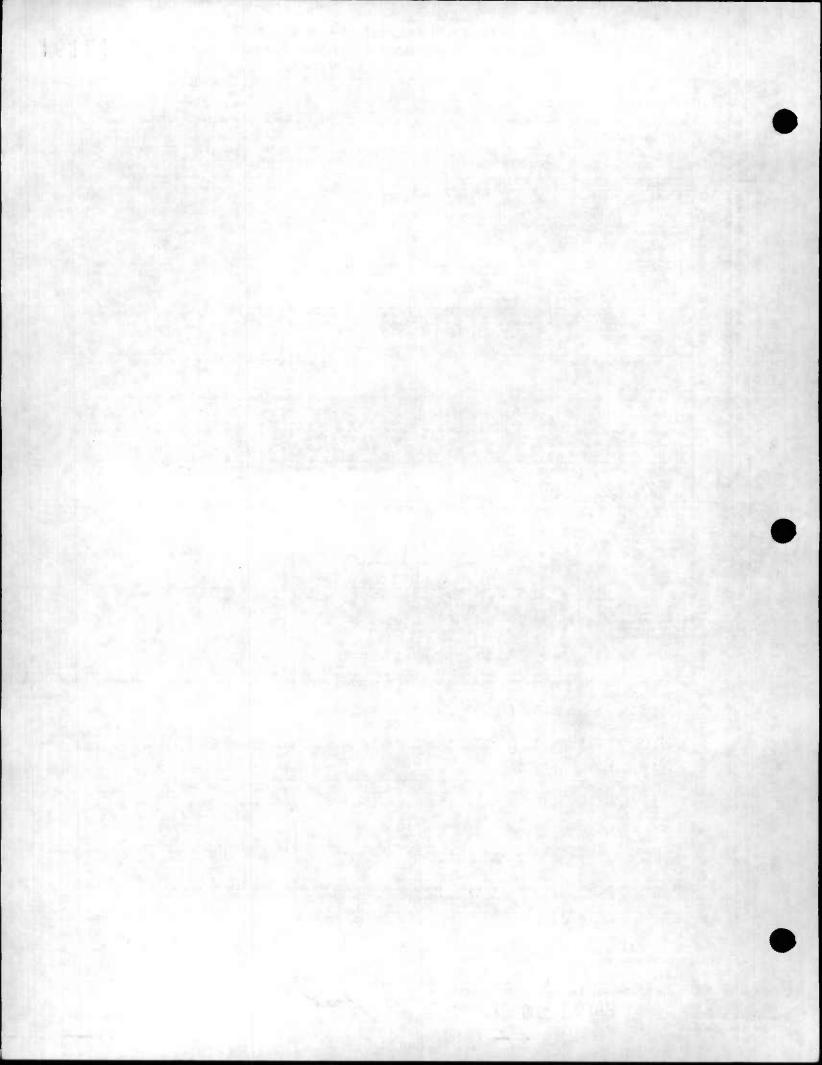
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21215-0020	be filed within 72 hours after death with the Maryland ral Hygiene. I other than "natural", or Nema 23a or 28a-f show avent, tre He sites Examinar must be notified.	Completed by Funeral Director	11. Marital Status 1 Nevar Marr 3 Widowed			12. Was Dace Armed For 1 1 Yes If Yes, Giv Year or Da	cas? 2 NWI:			s Decedent of as, specify Cu Yes 2 X N	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		e - Amarican Indian, ck, White, etc. White				
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Baiti	pemit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or any injury or other traumatic avent, tra Hasitas Eram page. To Be Completed by F		21. Signature of Fu	unarai Sarvice	Licen	saa A		,		22. Nama and Addrass of Facility Witzke Funeral Home 5555 Twin Knolls Rd Columbia, MD 21045								
			23a. Part 1, Entar to	he disease, o	or comp	olications that ca	aused the de	eath. Do	nof anter	the mode of d	ying, such as cardia	c or respiratory	arrast,		App	roximata rval Batween		
68760,	bhysician was a secured to the death certificate be executed when the attending physician and should be detached for use as the burial-transit of the business of the second of the seco	Fulcal Examiner	Immediate Cause disease or condition resulting in death) Sequentially list confarm, leading to in cause. Entar Unde Ceuse (Disease or that Initiated events resulting in death)	onditions, nmediate arlying liqury	{	a. R			conseque		nia							
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, P.O.	v requires that the death cer been signed by the attendin should be detached for use	y ruys	Part II. Other signif	. Car	di	ontributing to de	at but not r	esulting	in the unde	erlying cause (iven in Part I.				Probably	ceuse of death? 4 Unknown		
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R	ysician: The lav is certificate has director, page 2		Demen	itia.								1□	Yes 20	KNo	1 🗆 Yes	s 2□ No		
/ita	entifica ector,		25. Was case refer	red to medica	ai							ath (Check only	one)					
of	000	2	1 ☐ Yes 2 ☐							3LI DOA		Home 5 Res			pecify)			
no	ith. : After s funer		1 Natural 2 Accident	5 Pendi	ing tigation		of Injury h, Day Year)	280.	Time of injury	28c. In W	ork? ☐ Yes 2 ☐ No	28d. Dascribe	a now injury	occurred				
Divis	tal or Attending P rs after death. al Director: After t led in by the funera		3 ☐ Suicide 4 ☐ Homicide	6 Could daten	not be	Zoa. Place	of Injury - Al	home, f	arm, street	, factory, offic	0	28f. Location City or To	(Street and own, State)	Number or	Aural Aou	ute Number,		
۱	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Alcal C	29a. Certifier (Check only one)	Certifyi 2 Medica	ng Phy I Exam	yelcian: To the liner: On the ba and mann	sis of exami	nowledg nation ar	e, daath oo nd/or inves	ccurred at the tigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) a , data and	and mannar placa, and c	as stated dua to the	cause(s)		
	To the comp	-	29b. Signature end	title of certific	er						nsa nu <i>m</i> ber			signed (Mo				
			1	1-ke	w	8					31927		m	ay 24	P. 21	000		
/_	1		30. Name and addr	ess of person	Me	with ted cause	and the same of	em 23a)		vorth	Dr. C	plumbi	a. v	uD 2	104	5.		
3	State Registrar		31. Date filed (Mon	MAY 3	17	32. R	egistrar's Sig	nature	6	Apo	-							



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate of	Death		1	Reg. No.		
		1. Decedent's Name (First, Middle, Last,)					2. Date of Dea		Veed	3. Time of Death
	Physician	Ruth B.	. Scarff					Month	26, 200	Year)()	10:15 AM
	/Medical Examiner	4a Facility Neme (If not institution, give				4b. City, To	wn, or Lo	cation of Death			20020
49	LXdiiiiici	Future Care Cherr				Reis	ters	town	Ba	altin	nore
-	Funeral	5. Social Security Number 6. Sec		yrs. lest birthdey	If Under 1 Yee			8. Dete of Birt	h	9. Birthr	olece (State or Foreign
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		Usual Residence of Decedent							•		J 1 4.11 4
	Aan Man	10a, State 10b, County	10	c. City, Town or Le	ocation					1	IOd. fnside City Limits
	Many Many Many Many Many Many Many Many	MD Baltimor	re	Rei	sterstow	n					1 ☐ Yes 2 ☐XNo
	vith the Mai t or 28s-f s be notthed Director	10e. Street and Number			10f. Zip Code			Т	10g. Citizen of W	hat Cour	ntry?
	\$ 0 0 O		ne			136			USA		
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	ar d	11. Marital Status	Armed Forces?	11 0,5.	Wes Decedent of If Yes, specify Cu	ban, Mexican	, Puerto	Rican, etc.)	Black	k, White,	
20	ar, or		If Yes, Give Yeer or Dates:		1□ Yes 2⊠ N	Specify:			Specify:	141	nite
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21215-0020	ed within 72 ho ygiene. er than "natura ft, the Medical ft, the Medical	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most	of worki	ing	16b. Kind of Bus	siness/in	dustry
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X	T Branch	Andrew	Beveridge					gusta	Sip		
Maryland	2 sho	19e. Informent's Name/Relationship (Ty R. Janet Ball			ing Address (Street						
_	1 and Health am 27 Wher tr	R. Janet Ball	Daughter	22 B	errymans	Lane,	Ren	stersto	wn, Mary	/land	21136
ore	of Hear	20a. Method of Disposition		Ob. Placa of Disponentery, cre	osition (Neme of matory or other p	(ece)	ì	Date	20c. Location - (City or To	own, State
Ĕ		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	temoval from State	Loudon P.			5	/30/00	Baltimo	ore,	Maryland
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		and &	June		line Fun					וט ע	21136
Te i		23a. Part1. Enter the disease, or compleshock, or heart tailure. List only or	ne cause on each line.	death. Do not en	ter the mode of o	ying, such as	cardiac	or respiretory er	1651,		Approximete Interval Between Onset and Deeth
	Physician		/) -	^	(1	-	7			Chast and Destin
49	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	. (2000	ers t	NE		V1)ec	ye	:	57e~
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0	Attending or death. actor: After the fune by the fune fillcation.	2 Accident investigation				Yes 2	No				
Division	Atte ar de secto by ti	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, st	reet, factory, offic	е		28f. Location (S City or Tov		er or Run	al Route Number,
Ö	lal or Attending P rs star death. al Director: After t ed in by the funers Certification:		building, etc. (c	pocny				0.07 0.7 0.7	, 0.0.0.,		
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	he Hospit in 24 hour he Funer pletely fill edical	(Check only one) 2 Medical Examin	ner: On the basis of exe and manner stated		ivestigation, in my	opinion, dea	th occurr	ed at the time,	date and place, s	nd due t	o the cause(s)
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	200	30 Name and	ampleted assure of the co	(llom 00-) (T	Drint)	01		A	(4)	20	1
(00	30. Name and address of pelson who co	or death	(Item 23e) (Type		TAL	R	1 D. L.	III DA	2	1200
	71	31. Date filed (Month, Day, Year)	e and for	Signature /	, There	- wed	14	VI LIVES	ماراف	L	120
	State Registrar	MAY 3 1 2000	hewar	4 An	n V						

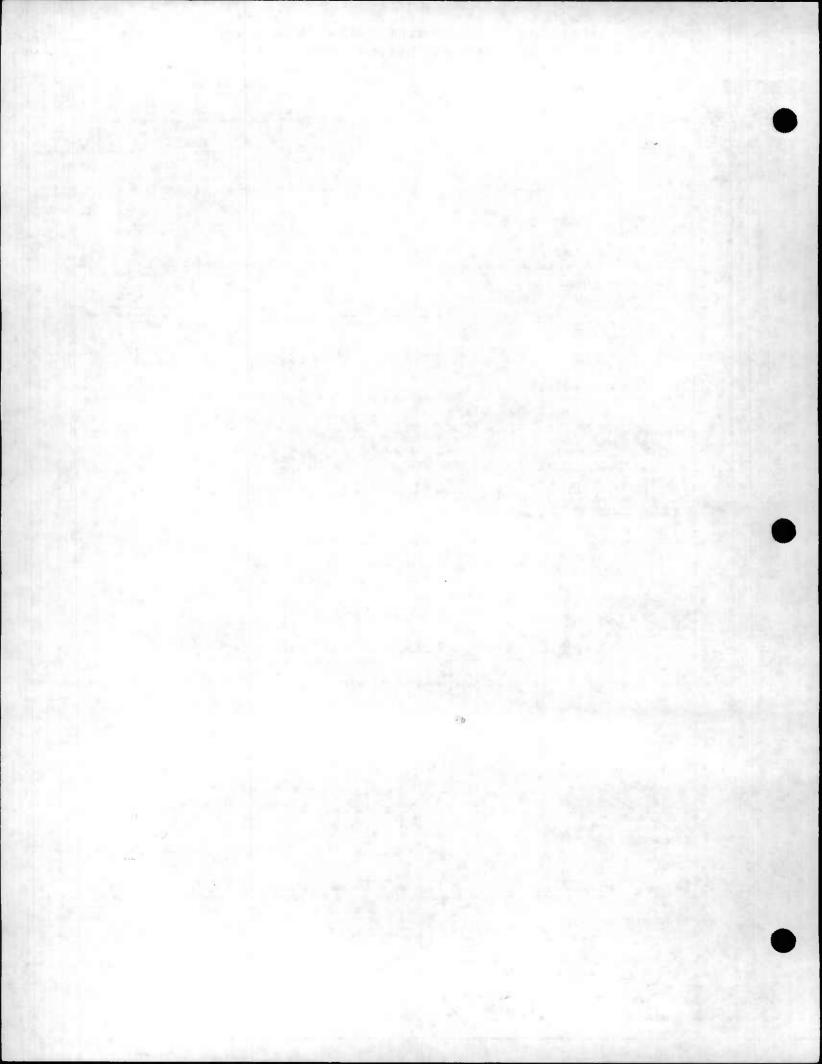
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				Cei	rtificate	e of l	Death		1	Reg. No.			
, , []	1. Decedenl's Name (First, Middle,	Last)							2. Date of Dea	ath Day	Year	3. Time of Death	
ician dical	Eleanor Lillia	n Schmidt							MAY 29	, 2000	i edi	21:58	
cai ner	4a Facility Name (II not Institution,	give street and numb	ber)	171		4	b. City, To	wn, or Lo	ocation of Death	4c. Cour	ty of Death		
	St. Agnes Hos	pital					Balt	imon	ce		N/A		
		S. Sex 7	. Age (In yrs. last	birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h V Voor)	9. Birth	place (Stete or Fore	
	213-26-3046	1□M 2⊠F	78	Yrs.	Working	Days	riours	IVIIII.	Dec. 08			yland	
	Usual Residence of Decedent		1.0 0"										
	10a. Slate 10b. County		10c. City, T	own or Lo	ocation							10d. Inside City Limi	
cto	Maryland N/A		Ba1	timo	re							TLX Tes 2UT	
Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen o	f What Cou	intry?	
Funeral	3320 Benson Av						2122				d Sta		
1	11. Marital Slatus	12. Was Deced Armed Forced	lent Ever in U,S.	13.	Was Deced	ent of H	ispanic Ori In, Mexicar	gin? (Sp.	ecify Yes or No- Rican, etc.)	14. R	ace - Ameri ack, White	can Indian, , etc.	
	1 Never Married 2 Marrie	If Yes, Give			1□Yes 2	- CKNo	Specify:			Spec	ify: TTL 2		
	3 □ Widowed 4 □ Divorced	Year or Dat	es:						TE TO		WIII		
	15. Decedent's (Specify only highest	Education grade completed)		6a. Deced	dent's Usua kind of wor DO NOT us	k done	ation du <i>ring</i> mos	t of work	ing	16b. Kind of	Business/Ir	ndustry	
Сотриете	Elementary/Secondary (0-12)	College (1-4	4or 5+)			e retired	9)				77		
	6			Home	maker		40 14-41-	-d- Al	- (Fire A. B. Airdelle		Home		
9	17. Father's Name (First, Middle, Li								e (First, Middle,		9111 8)		
9	William E. McCub								Cloud (- 1	(a V)	
	19a. Informant's Name/Relationshi			19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Co 226 Glenrae Drive Catonsville, MD 21228						p Code)			
	Bertha Rowley (D	augnter)	000				rive	cato		-			
	20a. Method of Disposition 1 StBurial 2 ☐ Cremation 3	□Removal from St	cem	e of Dispo	osition (Nen metory or o	ther plea	ce)		Date	20c. Locatio	1 - City or I	own, State	
	4 □ Donation 5 □ Other (Spe		Meado	wrid	ge Me	mori	lal Pa	ark (5/2/00	Elkrid	lge, M	ID	
	21. Signature of Funeral Service Li	cersion) 22	2. Name an	d Addres	ss of Facili	yAmb	rose Fur	neral H	lome,	Inc.	
	Sharron Mills 1328 Sulphur Spring Road Arbutus, MD												
	23a. Part1. Enter the disease, or c shock, or heart lailure. List or	, ,	Approximate Interval Between										
	shock, or heart lailure. List or	niy one cau se on c a	ch line.								i	Onset and Death	
	Immediate Cause (Final		HYP.	ER 1	KAZI	Em.	A					2	
	disease or condition resulting in death)				1	•							
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Š	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					2 0							
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cermicanon.	1 Natural 5 ☐ Pending	(Month,	Dey Year)	Injury	M	8c. Injur Wor	yat k? Yes 2□	No	Log. Describe i	rigury occ	unou		
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-	4 Homicide determin	ed Zoe. Place o	of Injury - At home g, etc. (Specify)	, raffii, Stf	et, lactory	, onice			City or Tov		VI TU	a. mode maniper,	
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	(Check only 2 Medical Ex	Physician: To the bas aminer: On the bas	is of examination										
Medical	29h Signature and title of certifier	and manne	er stated.		200	Licens	e number			29d. Date sig	ned /Month	Day Year)	
	29b. Signature and title of certifier	1-11	21)		290	10	05/	86	5	MA	7 2	9 2000	
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	30. Name and address of person w				Print)	a	100	141	15017	777	BA	LIMO	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30, **Emma** Spangler Stinson May 2000 6:30 a.m. 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5501 Morello Road Baltimore City N/A If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days 213-01-1188 Yrs 91 1909 Baltimore, Md. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Yes 2 □ No Md. N/A Baltimore City 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5501 Morello Road 21214 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Meritel Stetus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Stinson Catherine Warner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sue Snyder (Niece) 5501 Morello Road Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery 6/1/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerai Service Licensee 22. Name end Address of Fecility Milton J Knight Jr Leonard J. Ruck, Inc. iltor 5305 Harford Road Baltimore, Maryland 21214 complications that daused the daush. Do not enter the mode of dying, such as cardiec or respiretory errest, only one cause of Jach line. Approximete Intervat Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart faiture. List Immediate Cause (Final disease or condition resulting in death) RELAL FASLURE FROM DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ₺ Unknown 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 26d. Describe how Injury occurred

1 ☐ Yes 2 ☐ No

00053686

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21239

Balt

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

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2

Funeral

Director

28a-1

23a or

8

Hygiene.

permit. Pages 1 and 2 should be fix Department of Health and Manial Hy Important: If them 27 is manked other any injury or other traumests event

filed within 72 hours after

Baltimore, Maryland 21215-0020

by Physician/Medical Examiner the bunal-transit for use as Completed **page 2** Be Medical Certification: To

The law requires that the death certificate be executed and Box 68760, physician signed by the a d be detached f P.0. Division of Vital Records, After this certificate hes or Attending Physician: s after death.

It Director: After this be in by the funeral d

To the Hospital o within 24 hours aft To the Funeral DI completely filled in

State Registrar

MMER 31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

1 Natural

2 Accident

4 | Homicide

29b. Signature and title uld

3 Suicide

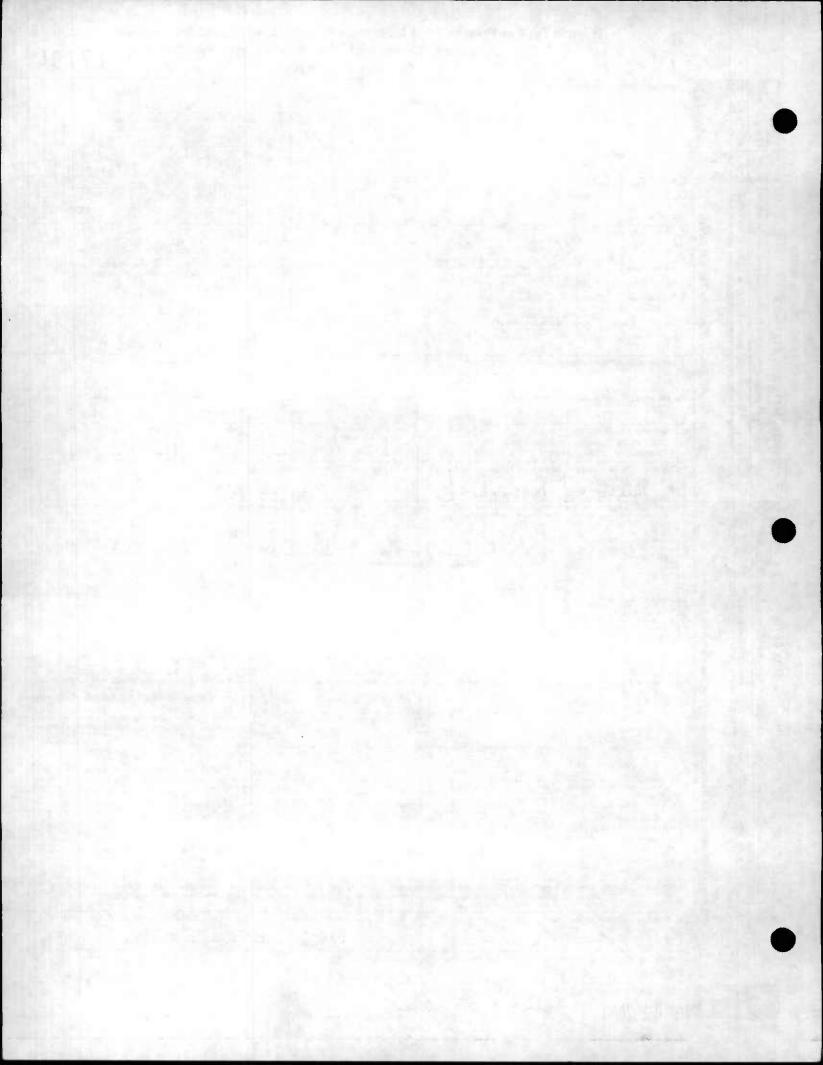
29a. Certifier (Check only

> 00 32. Registrar's Signature

30. Name and andress of person who completed cause of death (item 23a) (Type, Print)

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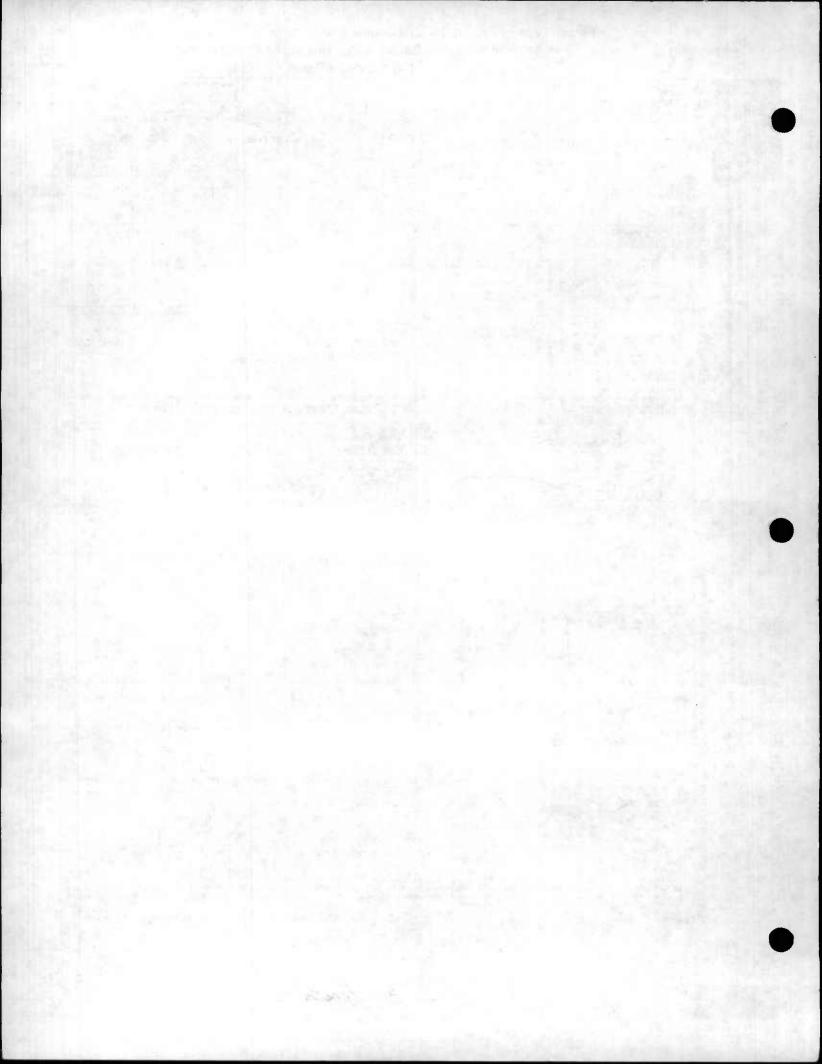
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Day Month Vaar **Physician** GT 0.5 11:30 Am STATUTE 2000 /Medical 4e Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD HOSATAL COLUMBIA HOWARD COUNTY LIGNERAL H Under 1 Yeer | H Under 24 Hrs. | 8. Data of Birth (Month, Pay, Yaar) | September 13, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 6. Sex **Funeral** 165-38-7551 1 M AD-F 79 Yrs. Director Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits The Maryla d Hygiane. Other than 'netural', or flams 23s or 28s-f et went, the Medical Examiner must be notified NI Sewell. XX Yas 2 □ No Gloucester Director 10e Street and Number 10f. Zin Code 10g. Citizan of What Country? 08080 15 Freedom Road TEA Funeral 14. Raca - Amarican Indian, Black, White, atc. 12. Was Dacedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status hours after 1 Yas 2 2010 If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married White Maryland 21215-0020 1 Yas 2 No Specify: Specify: 3℃ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry be filed within 72 Elemantary/Secondary (0-12) Collaga (1-4or 5+) Registered Nurse Hospital 12 4 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be 7 Health and Mental Item 27 is marked o William Navitsky Anna Velvis permit. Pages 1 and 2 should Department of Health and Men mportant: If item 27 is markee To 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Valerie Statute / 7840 Canter Court, Severn Maryland 21144 Daughter Baltimore, 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete Data 20a Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 302 Removal from Stata 6 St. Joseph Cemetery June 5, 2000 Swedesboro, NJ 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Fecility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland Signatura of Funaral Sarvice Licensee Victor P. Doda, 21230 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** /Medical immediate Cause (Final DOYS disease or condition rasulting in death) PSIS Examiner Dua to (or as a consequanca of): Examiner FERT MENTHS -URE The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadieta causa. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last burial-tren Dua to (or as a consaquanca of): physician Box 68760, Physician/Medical the Dua to (or as a consaquanca of): P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings eveilable prior to 24a. Wes an eutopsy performed? Completed peed PGRIENSION complation of causa of daeth? pege 2 this certificate hes 2 10 No 1 Yas 1 ☐ Yas 2 ☐ No of Vitai or Attending Physician: director, 25. Was casa ratarred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Vas 250 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) funerel 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After t 5 Panding invastigation Division Natural i after death.
I Director: After in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 T Homicida To the Hospital within 24 hours a To the Funeral Completely filled Hospital Certifying Phyeician: To the best of my knowledge, death occurred at tha time, data and place, and dua to the causa(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) and manner stated. 29a. Certifian (Check only one) 29b. Signatura and titla of certifier 29c. Licensa number 29d. Dete signed (Month, Dey, Year) D42680 05:26.2000 6 mo 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) SABA SHEIKH M.D BALTIMORE NATIONAL PIKE 46 ELLICOTT CITY MD 21042 9051 31. Data filed (Month, Day, Year) sporks 32. Ragistrar's Signatura Gener Registrar

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Year **Physician** SchulTZ 1443 MAY William 28 2000 /Medical 4b. City, Town, or Location of Death 4s Facility Name (If not institution, give street and number) 4c. County of Death Examiner Lorien Nursing Home Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** Months Days 1 M 2□ F Yrs. Director 79 Sept. 17, 1920 Washington D.C. 578-12-2699 Usuat Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryler Department of Health and Mental Hygiana. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show why Injury or other traumatic event, the Hedical Examinat must be notified at once. 10d. Inside City Limits 1 Yas 2 No Director Ashton Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizan of What Country? USA 20861 18008 New Hampshire Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M/Yes 2 □ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14 Baca - American Indian Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married Specify: White 3aitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ۵ 3) Widowed 4 □ Divorced Completed 16b. Kind of Businass/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Excavation Contractor 18. Mother's Nama (First, Middla, Maiden Surnama) 17. Father's Name (First, Middle, Last) Be Harriet (Hooker) 2 Charles Schultz 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 9266 Cherry Lane #55, Laurel, MD 20708 Cathy Rosenberger 20b. Place of Disposition (Nama of cemetary, crematory or other place, 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata
4 Dongtion 5 Other (Specify) 5/31/00 Laurel, MD Balt.-Wash. Crematory 22. Nama and Addrass of Facility Fleck Funeral Home 21. Signature of Funeral Service Lice 7601 Sandy Spring Road, Laurel, MD 20707 23a / u.t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Physician Immediata Causa (Finat disease or condition resulting in death) /Medical End Stage renal disease Examiner Due to (or as a consequence of): Examiner Hypertenson' sicien end burlei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): strending physicien for use as the burle P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? should be detached 1 Yas 2 No 3 Probably 4 Unknown Dementra Records, 2 24b. Wara autopsy findings available prior to complation of cause of death? Colon Cancer Completed 24a. Was an autopsy fracture Mb 1 ☐ Yes 2 No 1 Yes 2 No this certificate Division of Vital of attending Physician: effar death. Director: Affer this certifica 25. Was cash refarred to medical 8 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidenca 8 Other (Specify) 1 Yes 2 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical

State **DHMH 16 Rev 6/95**

Registrar

31. Date filed (Month, Day, Yest) MAY 3 1

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tena

29b. Signature and titla of certifier

Ho-Lai

Iwo 32. Registrar's Signature

mi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mD

Knoll North

29c. License number

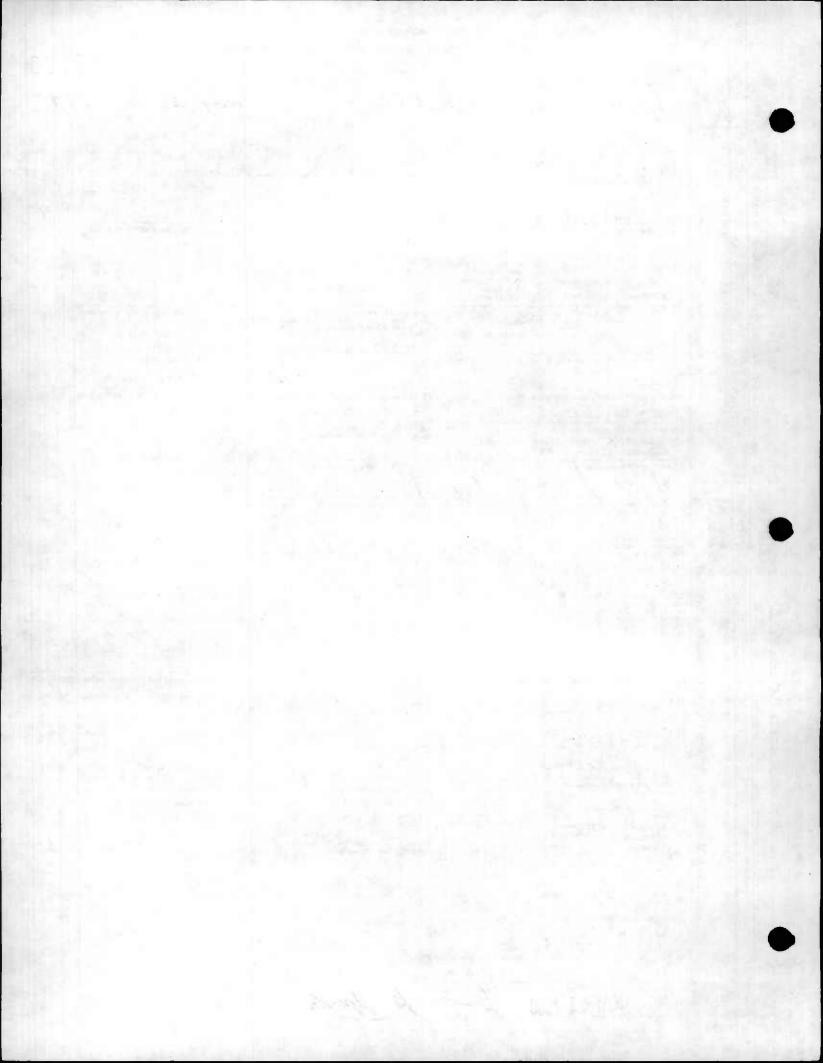
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Columbia

29d. Date signed (Month, Day, Year)

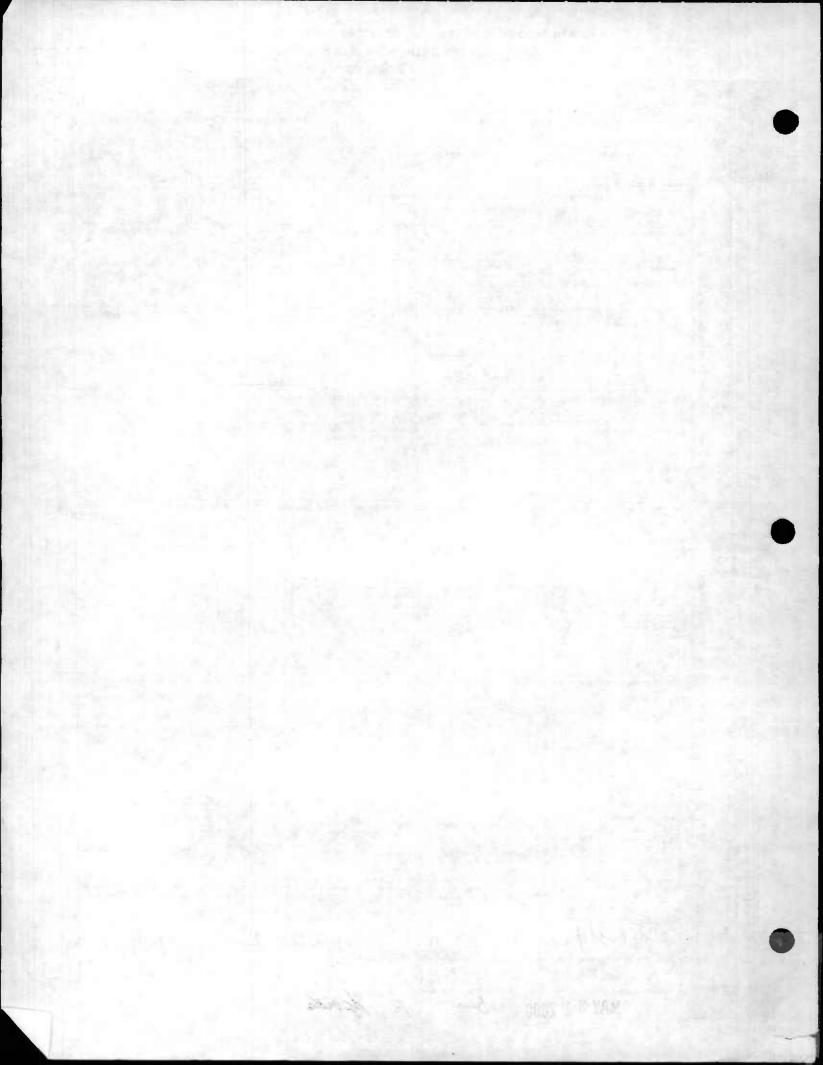
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State of Maryland / Department of Health and Mental Hygiene 00 17107

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al er			 SCRUITL ve street end number 					4b. City, Town,	, or Location	26 of Deeth	4c. County of	-		
	1500 CHA	PEL HILL	DRIVE					ROSEDAI	L.E.		BALTI	MORE		
	5. Social Security 219 74 Usual Residence	1491	Sex 7. / 1 ☐ M 2 🛣 F	lge (In yrs.	9 Yrs.	If Under Months	1 Year Deys		Min. 8. Da	te of Birth onth, Dey, Y 26 1	^(ear) 910 (9. Birthp Coun GERMA	lace (Stete of try)	r Foreign
ŀ	10a. Stete	10b. County		10c. Cit	y, Town or Lo	cation						11	0d. Inside C	
l	MD	BALTIMO	RE	ROS	SEDALE								1 🗆 Yes	34 No
	10e. Street and N		DDTUE			10f. Zip	Code 237	LPS. A.		100	. Citizen of W USA	hat Coun	itry?	
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	(Spe	15. Decedent's E	ducation		16a. Deced	dent's Usua	el Occup	pation during most of	working	16	b. Kind of Bu	siness/Inc	dustry	
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	17 Father's Name	e (First, Middle, Las	0			HOME	MAKE		Name (First	Middle Ma	OWN I			
	JOSEPH	LEY	,					ANNA N	MARTA	THERES	SE GROS			
		Name/Relationship	(Type, Print)		19b. Mailir	ng Address	s (Street	and Number o	ESE MA	USE			Code)	
	115/11 - 15-1	M. SCHOT		ICHTE				IILL DR						
	20a. Method of Di	sposition	☐Removal from Sta	20b. F	Plece of Disponentery, crer	netory or o	me of other ple		Dat	9 20	ALTIMOR	City or To		
	23a. Pert1. Enter shock, or he limmediate Cause disease or condition resulting in death Sequentially list of if any, leading to cause. Enter Un Cause (Disease that Initiated ever	e (Final cion) conditions, immediate derlying or injury	e b	Due to (d	or as a consecutor as a consec	quence of):	Lu:	SACO_AVI	rdiac or resp	ratory erres	,		Approxime interval Be Onset and	Death
	resulting in death) Last	l d			quence of):								
	resulting in death) Last	l d	L.A.				ines in Doubl		25 Did tob			o the cause	of death?
	resulting in death) Last	dcontributing to death	but not res				iven in Part I.	2	3b. Did tob	acco usa con		o the cause bably 4	
	resulting in death) Last		but not res				iven in Part I.			2 No	3☐ Pro		Unknow findings
	resulting in death) Last		but not res				iven in Part I.		1 ☐ Ysa	autopsy ed?	3 Pro	bably 4 ere autopsy allable prior	findings to ceuse
	Pert II. Other sign 25. Wes case ref axaminer?	nificant conditions	contributing to death		sulting in the u	inderlying o	cause gi	26. Place of	2 1 Deeth (Che	1 Yes	autopsy ed?	3 Pro	iere autopsy allable prior mpletion of death?	findings to ceuse
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2 2000 FRANK SICKENBERGER la /Medical 4a Facility Name (If not institution, give street end number) 45. City, Town, or Location of Death Ac. County of Death Examiner ale Himore Squar 0.50 a If Under Year | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 6 Sex **Funeral** 1 M 20 F Months Days Hours Yrs. 192 12 3680 Director FEB 9 1924 PENNSYLVANIA 76 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow 1 Yes 2 No Director MD BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23s 1214 BERK AVENUE 21237 Funeral USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marifal Status Black, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: if item 27 is marked other than 9 my Injury or other traumatic event, the Mapine. Elementary/Secondary (0-12) College (1-4or 5+) MACHINERY 12 SPRAY PAINTER Maryland 17. Fafher's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surneme) Be TRACY SICKENBERGER HELEN RICE 19a. fnformant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY B. SICKENBERGER/WIFE 1214 BERK AVENUE BALTIMORE. MD 21237 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State GARDENS OF FAITH 4 ☐ Donation 5 ☐ Other (Specify) 5/29/00 BALTIMORE, MD 21. Signature of Funeral Survice Licansee 22. Nama and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate fnterval Between Onset and Deeth **Physician** fmmediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequenca of): Physician/Medical Examiner ed by the attending physician and detached for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enfer Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or es a consequença of) Part II. Other significant conditions contributing to death but not resulting in tha 23b. Did tobseco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funerel Director: , completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier ŝ 29d. Dafa signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Maryland 21237 9000 franklin Square Drive Baltimore DR Rachel Benn 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

State
Registrar

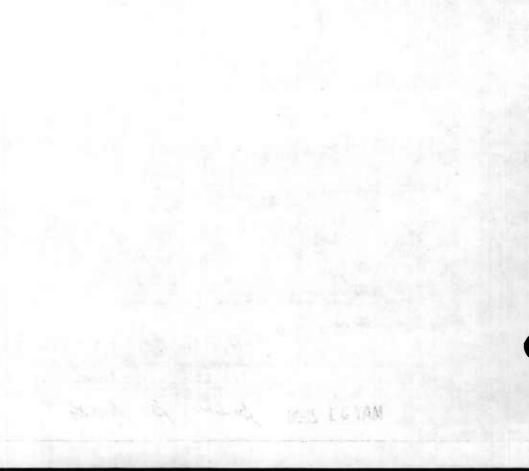
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Sickenberger

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2. Registrar's Signature

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Use Color	me of Death 45pm		
Social			
Too. Sale 100. County 100. City, Town or Location 101. Zip Code 102. Zip Code 103. Zip Code 105. Z	9. Birthplace (State or Foreign Country)		
1 Never Married 2 Married 2 Married 2 Married 1 Never Married 2 New Married 1 Never Married 2 New Married 1 Never Marrie	ide City Limits		
Elemenglery/Secondary (0-12) 4 College (1-for 5+) Mechanical Engineer Mechanical Engineer Mechanical Engineer Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Summen) Anna Diminico 19. Informant's Name/Relationship (Type, Print) Mrs. Albina R. Spada / Wife 204 Locknell Road Lutherville, Maryland 21093 205 Maihod of Disposition 1/1 Durie 1 2 Oremain on 3 Demonstration of Summers of	Yes 2/ No		
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Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part I. Enter the disease of compliants that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a consequence of the cause of conditions are allowed in the cause of conditions. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobsecc use contribute to the cause library performed? 24a. Was an autopsy performed? 24b. Were auto available properties of death? 1 Yes 2 No 3 Probably 24a. Was an autopsy performed? 25b. Was case referred to medical examiner? Hospital: Double to (or as a consequence of): 26c. Place of Deeth (Check only one)			
RUCK TOWSON Funeral Flome, Inc. Towson, Md. 21204 Sale Part Enter the disease of compliants that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any ofe ceuse opeach line. Approximately shock, or heart failure et any of et any of et any of et al. Approximately shock, or heart failure et any of et any of et al. Approximately shock, or heart failure et any of et any of et al. Approximately shock, or heart failure et any of et al. Approximately shock, or heart failure et any of et al. Approximately shock, or heart failure et any of et al. Approximately shock, or heart failure et any of et al. Approximately shock, or heart failure et any of et al. Approximately shock, or heart failure et an	nd .		
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	Number,		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as steted. (Check only one) Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause (s) and manner as steted.	iuse(s)		

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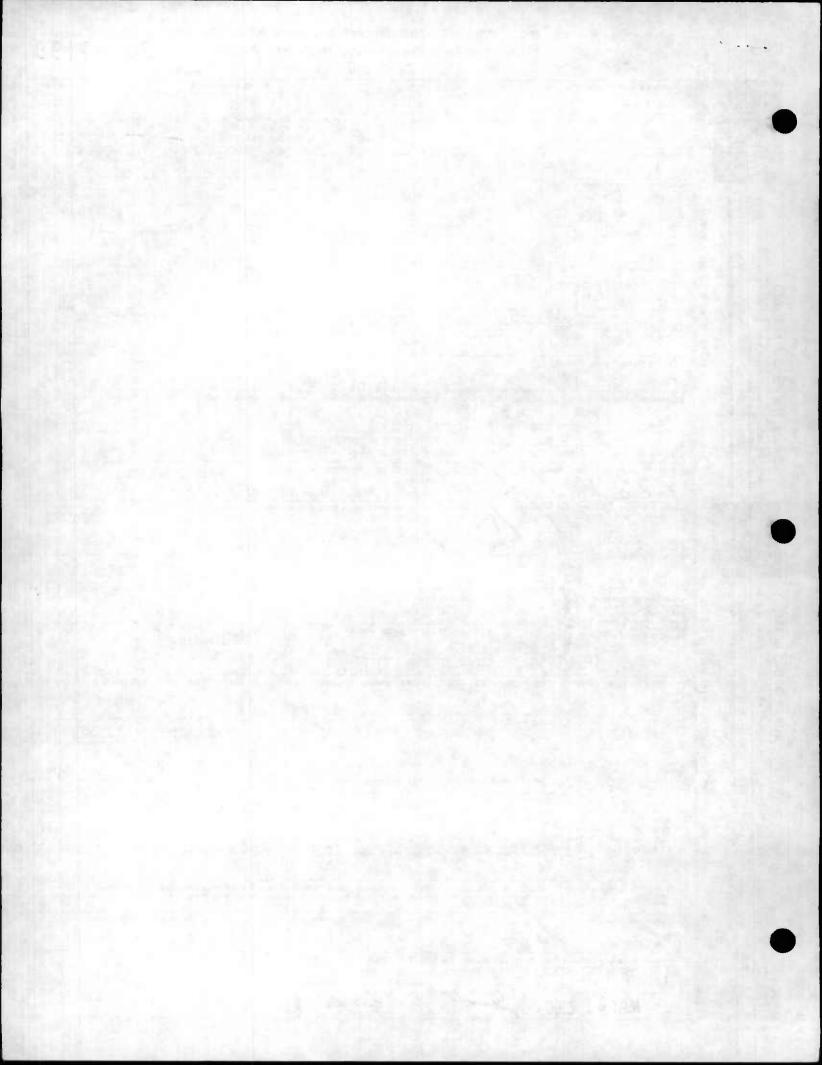
Registrar

ROBERT B.

31. Date filed (Month, Day, Year)

MAY 3 1 2000

SUTTE 605 1447 YORK Rd, 21093



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear 28 th **Physician** 2000 EDITH B. SACKS m /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner d- Baltimone N/A HUSpirol BALTIMORE If Under 24 Hrs. Birthplece (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys Months Hours 1 M 2 XF Yrs 215-32-3252 Director JAN. 18, 1908 MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28s-f show the Medical Examiner must be notified at 1 X Yes 2 □ No MD N/A Director BALTIMORE 10f Zin Code 10g. Citizen of What Country? 10e Street and Number than "natural", or items 23s or 7208 CHALKSTONE DRIVE #T-421208 U.S.A. Funeral 14. Race - American Indian Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. WHITE þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) pemit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other that any Injury or other treasment. 4 NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN SACKS MARY F. KIRSTEIN 0 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNARD SACKS / BROTHER 9900 MIDDLE MILL DRIVE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 X Buriai 2 ☐ Cremetion 3 ☐ Removai from S 5/30/00 ADATH YESHURUN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Sign 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 in caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. Approximate Intervel Between Onset and Death **Physician** fmmediate Ceuse (Final disease or condition resulting in death) /Medical SPIRATIUM Examiner Due to (or as a consequence of) Physician/Medical Examiner cumania The law requires that the death certificate be executed attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): P.0. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24a. Was an autopsy parformed? Were autopsy findings available prior to Completed peen completion of cause of death? page 2 certificate has 1 🗆 Yes 2 No 20 No 1 Yes or Attending Physician: 80 25. Was case referred to medical 26. Piace of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 20 No 2 2 ER/Outpatient 3 DOA Director: After this Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by after 4 Homicide within 24 hours a To the Funeral C Hospitai Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and menner as stated.

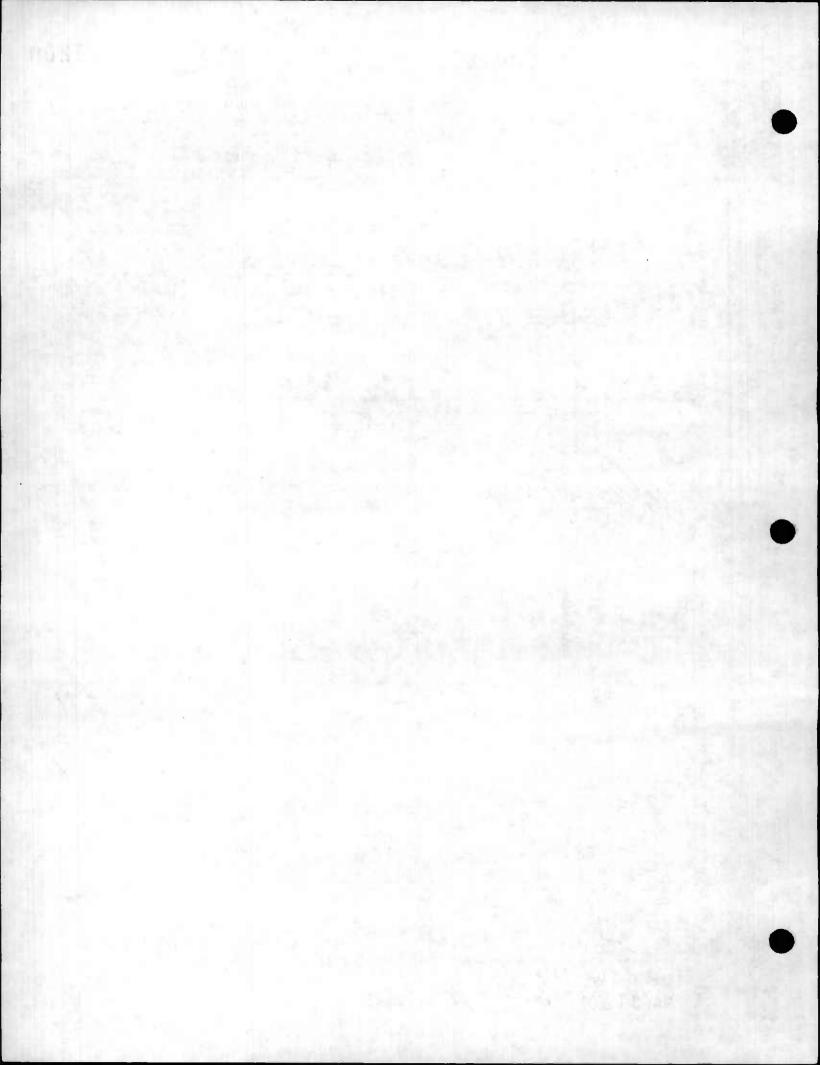
2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date end piace, end due to the cause(s) end menner steted. 29a. Certifier plataly To the 29b. Signature end title di certifier 29d. Date signed (Month, Dey, Year) 29c. License number

T

DHMH 16 Rev 6/95

State Registrar cson who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature



ELLA TOMSIK, NAME

Box 68760 P.O. | Records, Vital

certificate of this After Division or Attending death. Director: in by To the Hospital or within 24 hours aft To the Funeral Di completely filled in

attending physician and for use as the burial-transit certificate be executed

should be

peen

28a-f show

Baltimore, Maryland 21215-0020

Medical Certification: To

31. Date filed (Month, Day, Year) State MAY 3 1 Registrar

Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd 32. Registrar's Signature

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

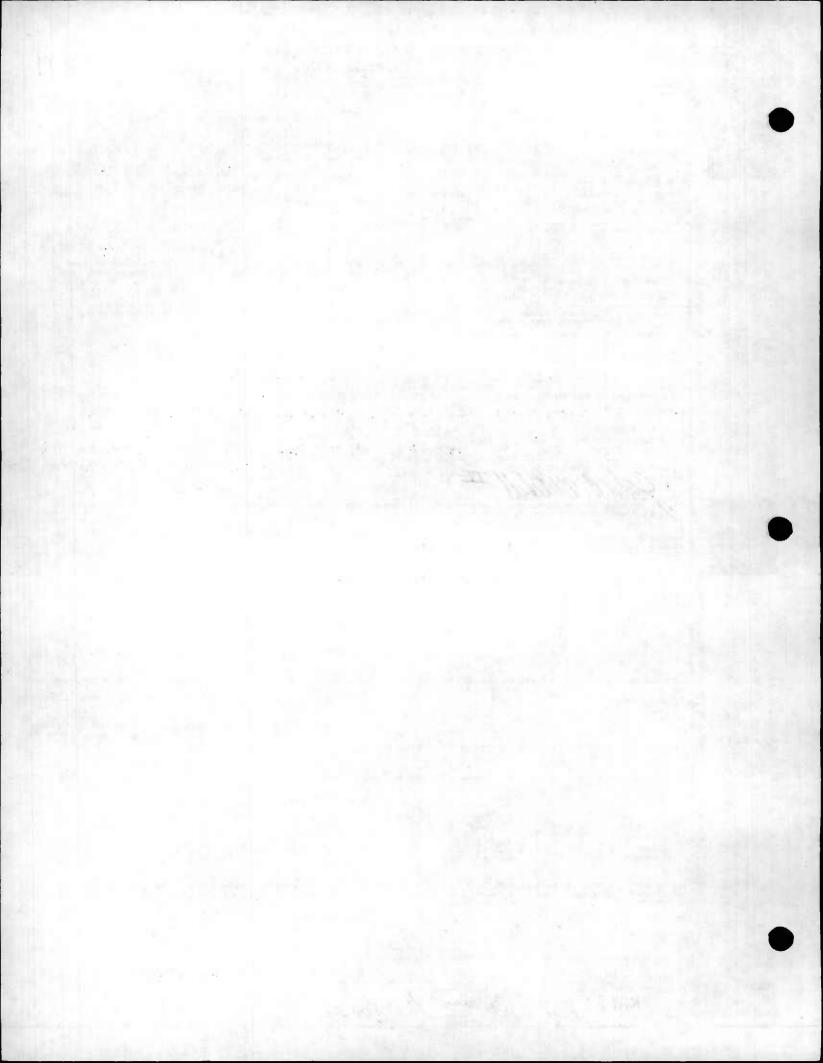
29c. License number

D 15504

29d. Date signed (Month, Day, Year)

6.30.00

Timonium, Md 21093



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month -46 AM **Physician** Wesle 25 2000 /Medical 4b. City, Town, or Location of Peath 4c. County of Death institution, give str Examiner 1000 Uheafon If Under 24 Hrs. 8. Georg Ta If Under 1 Year Months Days 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Sountry), 7. Age (th yrs. last birthday) **Funeral** 2□ € Months Yrs. Director with the Manyland 10b. County 10d. Inside City Limite 10a. State 10c. City. Town or Location 28a-f ahow Schenectua 1 XYes 2 No Director 10g. Citizen of Whet Country? 10e. Stree and Number ò 12. Wes Decedent Ever in U.S. Armed Forces? 2307 "natural", or items 23s 12307 101 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 25 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If them 27 is marked other the 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last 8 400 9 intoh 2015 19b. Mailing Address (Street and Number of Rurel Rouse Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Pnnt) 23663 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Method of Disposition cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 Removal from State ■ Donation 5 Other (Specify) 21. Signatur Funeral Service Licens 22. Name 21217 Part1. Enter the disease, or complications that caused the deeth, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such es **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examine ettending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as e conseque P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Winknown 1 ☐ Yee 2 ☐ No Division of Vital Records, by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of deeth? certificate hes 273 No 1 Yes 25. Was cese referred to medicel exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes ■ No 10 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed ceuse of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

Year)

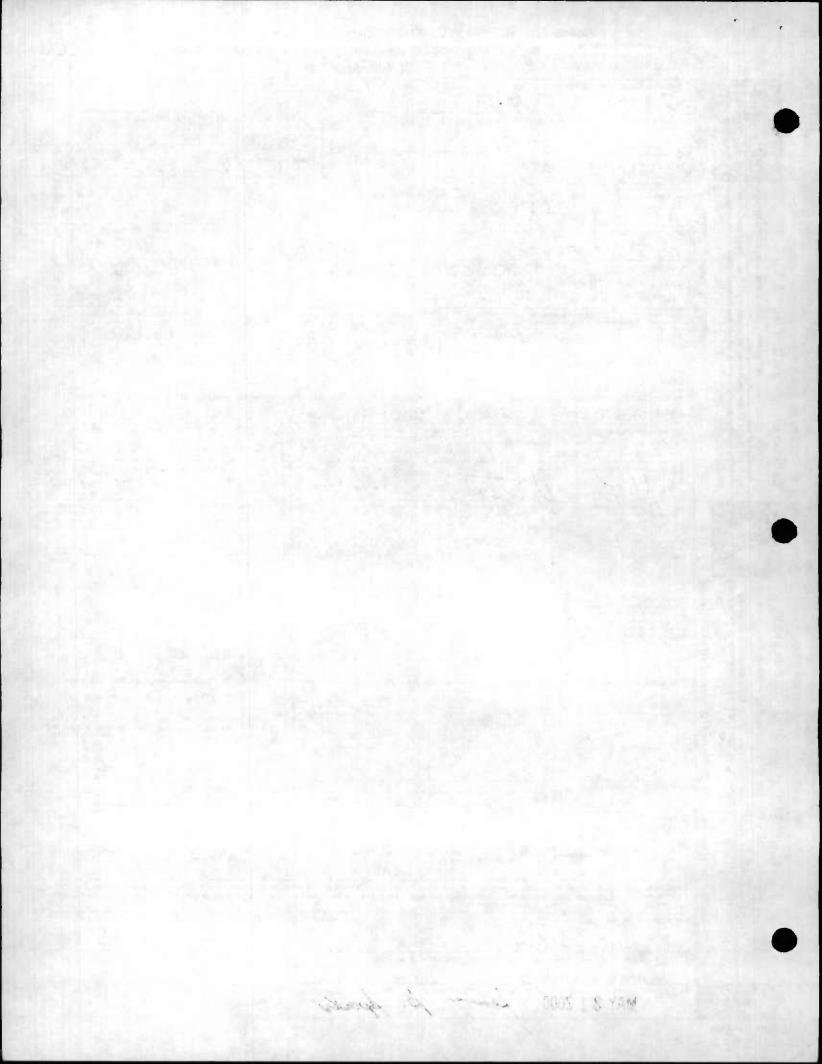
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32. Registrar's Signature

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CS, 00-2941-510 JOSEPH TAYLOF AMEND I	Please To AMEND.ITEM: # 100	ype or Print in Bi State of Waryand 27, 28A-F PER	ack Indelible	Ink. Assure A	all Copies ३.वस्थाः YRyg	Are Legit	le. 17203					
AMEND I	1. Decedent's Nama (First, Middla, Last)	AYLOR	MEC entificate	of Death	2. Data of Dea Month	th Dey	3. Tima of Death					
/Medical Examiner	4a Facility Nama (If not institution, giva st UNION MEMORIAL HO	treet and number)	4b. City, Town, or BALTI	MORE	2000 19:20 PM of Death							
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or 28s-f show be notified at Director	N.C. HALL FA	x w	ELDON 10f. Zip C	ode	l0g. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 🙀 No Thet Country?						
nter death with there 23e o older must be Furneral Di		Was Decedant Evar In U,S. Armed Forcas?	. 13. Was Deceda If Yas, specif	27890 nt of Hispanic Origin? (S y Cuban, Maxican, Puart	pecify Yas or No- o Rican, etc.)	U. S. A. 14. Race - Amarican Indian, Black, White, atc.						
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altimore, Maryland 21215-0020 mil. Pages 1 and 2 should be filed within 72 hours at portant of Healin and Mercial Hygens. portant if item 27 is marked other than "natural", or \$ injury or other traumetic event, the Medical Exam ca. To Be Completed by F	EDITH ARTIS (SISTER) 5605 GARDENVIUE AVE. BALLIMORE MD 21206 208. Mathod of Disposition 200. Place of Disposition (Name of campatary, crampatory or other place). Data 200. Location - City or Town, State											
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DIVISION O eptal or Attending Ph routs after death. neral Director: After th filled in by the funeral rail Certification:	27. Menner of Death 1 Neturel 5 Panding invastigation 3 Suicida 6 Could not be datarmined	28a. Date of Injury (Month, Day Year) FOUND: 5-27-00	Bb. Time of P 28 FOUND: M 6:35	c. Injury et Work? 1 ☐ Yas 2 ☒ No	28d. Describe h	ow injury occurr	ed er or Rural Routa Number					
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To the Ho within 24 I To the Fu completel	one) 29b. Signature and titla of certifiar	and mannar statad.	29c.	Licansa number		29d. Data signed (Month, Day, Year)						
	30. Nama and addrass of person who com	na	111 Penn S	O.C.M.E.	imore, M		21201					
State Registrar	31. Data filed (Month, Day, Year) MAY 3 1 2000	32. Registrar's Signetu	B. Apa	W								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** Alex Leonard Urban May 25, 2000 10:14 PM /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center For Hospice Care Towson Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days COM 2DF Yrs. Nov. 6,1920 168-12-6254 79 Pennsylvania Director Usuel Residence of Decedent r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen ot What Country? 605 48th Street 21224 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Merried 12 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specity: Š 3 Widowed 4 ☐ Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hydione. Important: if item 27 is marked other than "nat eny injury or other treumatic event, the Medical Color. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Delivery Man Pastry Products Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alex Urban Sophia Butchinski 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 14 Clearlake Ct. Baltimore, Maryland 21234 Mr. Leonard Urban (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sacred Ht. of Jesus Cem. 5/30/2000 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland ease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, we. List only one cause on each line. 23a. Pert1. Enter the disshock, or heart Approximate Interval Between Onset and Death **Physician** tmmediete Cause (Final disease or condition resulting in death) /Medical 14 month Examiner Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be ex Box 68760 Physician/Medical Due to (or as a consequence of) 0.0 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Records. þ 8 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No certificate of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 20 No 9,4 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c, Injury at Work? Alter Division 5 ☐ Pending Attending 1 DENatural after desth. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò e Funeral S 1At Certifying Physician: To the best of my loxowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier (Check only one) ser: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannagestated. To the Y within 2 To the P 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

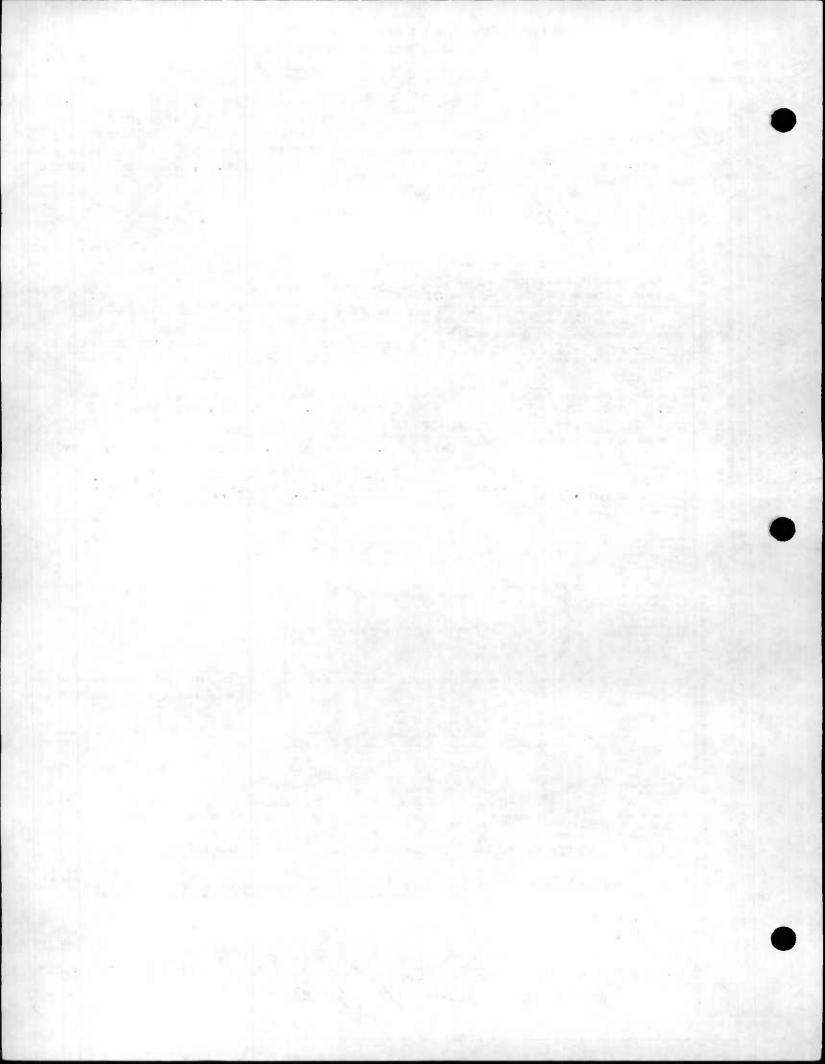
State

em 23a) (Type, Print)

6701

may 26, 2000

Charles St. patt md 2120x



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17205

E-1		1. Decedent's Name (First, Middle,	Last)	Cei			2. Date of Death					
Physician /Medical		Clifford Dar	rell Veenhui	S			MAY	26, 20	500 3:20 AM			
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Ya	Frederick Memo				Frede			derick				
	neral ector	473-48-2279	6. Sex 1⊊M 2□ F	(In yrs. last birthday) 55 Yrs.	If Under 1 Yea Months Day		8. Date of Birth (Month, Day Sept 17	1944	9. Birthplace (State or Forei Country) Minnesota			
fanyland	adail or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City MD Frederick Frederick 12XYes 2										
with the Maryland	be notified Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Coun										
020 urs after death	Examiner must by Funeral	11. Marital Status 1 □ Never Married 2 □ Merrie 3 □ Widowed 4 ♣ Divorced	pecify Yes or No- o Rican, etc.)	o- 14. Rece - American Indian, Black, White, etc. Specify: White								
21215-0020 d within 72 hours at piene.	t, the Medical	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	s Education grade completed) College (1-4or 5+	(Give		e during most of wor red)	king	6b. Kind of Busi				
2. 2. 4					Custod	7			rement Home			
Maryland 12 should be Ille h and Mental Hy	o Be	17. Father's Name (First, Middle, L. George Veenhui:					ne (First, Middle, M rtrude Ar	3.00				
Should Me	To	19e. Informant's Name/Reletionshi		19h Mailir	o Address (Stre	et and Number or Ru						
Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma M	The state of the s	Pamela J. Sath				eet Jacks						
Saltimore, emil. Pages 1 a hoparment of Nes	or othe	20a. Method of Disposition 1XX Burial 2 ☐ Cremation		20b. Place of Dispo cemetery, cren	sition (Name of natory or other p	viace)	Date 2	0c. Location - C	ity or Town, State			
Itin	injury	4 Donetion 5 Other (Special Service L	ecify)	Sunset N			/01/2000		on, Minnesot			
B F	18) Da.(br.	1 -	502 Win	ress of Facility Ca	o Boltimo	al Serv	yland 21215			
		23a. Part1, Enter the disease, or o	or nicelions that coused to my one cause on each line						Approximele Interval Between			
60, be executed Exam	Examiner Language	Immediate Cause (Finet disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. 2° esoph	bleding, ue to (or es e consed agent Ca ue to (or as a conseq		ophago ga.	stric an	asteno				
Box 68760, sath certificate be expending physician	5 8	that initiated events resulting In death) Last	d	ue to (or es a conseq	uenca of):				1.4/12			
O. B. deat	sicle	Part II. Other significant condition	s contributing to death but	not resulting in the u	nderlying ceuse	given in Part I.	23b. Did to	bacco uae cont	ribute to the cause of deat			
	res that the death ce signed by the attendi I be deteched for use by Physician/I	1 □ Yes 2 □ No 3 ☑ P										
S, P.O.	8 >								24b. Were autopsy finding			
Records, P.O. Box 68760, law requires that the death certificate be executed that been stoned by the attending physician end	b b						24a. Was ar perform	ned?	available prior to completion of cause of death?			
al Records, P.C.: The law requires that the cete has been signed by it	pege 2 should be d						24a. Was ar perform		available prior to completion of cause			
Vital Records, P.C sician: The law requires that the certificate has been signed by it	rector, page 2 should be d	25. Wes cese referred to medical examiner?	Hospitat:			Other:	perform 1 ☐ Ye ath (Check only one	s 212No	available prior to completion of cause of death?			
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Division of Vital R Hospital or Attending Physician: The 24 hours effer deeth.	By filled in by the funeral director, page 2 should be dical Certification: To Be Completed by	examiner? 1 Yes 2 No 27. Menner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying	28a. Date of Injury (Month, Day)	/ear) 28b. Time of Injury - At home, farm, str. (Specify) my knowledge, death xamination and/or inv	28c. In W 1 1 eet, factory, office a occurred at the	Other: 4 Nursing H jury at /ork? Yes 2 No	perform 1 Ye ath (Check only one 1 Reside 28d. Describe ho 28f. Location (Shr City or Town	s 2 No a) nce 6 Other w injury occurre weet and Number , State)	available prior to completion of cause of death? 1 □ Yes 2 □ No (Specify) d or or Rural Route Number,			
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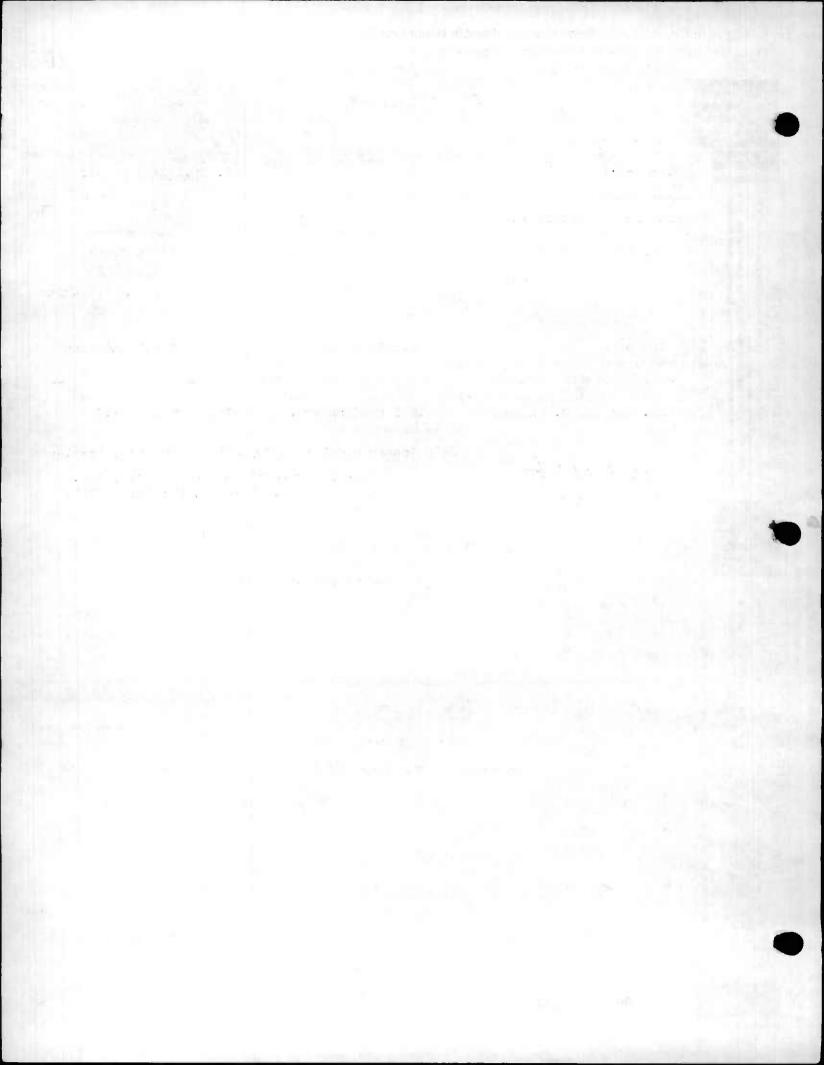
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Physicla	_				00,		Dealli		Reg. No.				
/Medica	an	1. Decedent's Name (First, Middle) Stanle		1, 34	Victe	orive		2. Dete of D Month	eath Day Z6	Year	3. Tima of Death 7:20.4		
Examine uneral	er	4a. Facility Name (If not institution, Tohns Hapkins 5. Social Security Number 575-20-0339	Bay even	. Age (In yrs. le	est birthday) Yrs.	If Undar 1 Year Months Days	Bal+	Vlin. (Month, D	irth ey, Year)	9. Birthpi	N/A eca (State or Foreity)		
rectors	1	Usuel Residence of Decedent		75				Oct.	26,1924	Haw	aii		
r 28a-f show		10a. State 10b. County Maryland Bal	ltimore	10c. City,	Town or Lo		ındalk			10	d. Inside City Lim		
28	Se	10e. Street end Number	remore			10f. Zip Code	ilidalk		10g. Citizen of	What Coun	ry?		
23a or	0	1903 Crafton A	Avenue				21222	,	Unite	c+2 5	tos		
ritems 23s or 28s-1s direct mast be notified Funeral Director		11. Marital Stetus	12. Was Deced	ent Ever in U,S	. 13. V	Vas Decedent of		? (Specify Yes or N uerto Rican, etc.)		ce - Americ	en Indien,		
Important: If them 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinations once. To Be Completed by Funer	þ	1 Never Married 2 Married 3 Widowed 4 Divorced		□No	1	Yes 2X No		uento Rican, etc.)	Specif	ck, White, o	White		
netur Sical	e e	15. Decedent's (Specify only highest	s Education		16a. Deced	ent's Usual Occu	pation	warklag	16b. Kind of B	usiness/ind	ustry		
A S	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	Steelworker			WOTKING					
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er traum		19e. Informant's Name/Relationsh Mrs. Frances							ber, City or Town, State, Zip Code) Maryland 21222				
int: If itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other ☑		ate cer	metery, crem	sition (Neme of netory or other pla ary Ceme		Date 30/2000	20c. Location		m, Stata Maryland		
Importa any inju once.	1	21. Signature of Fundal Service L	in an			Name and Addr Duda-Ru	ess of Fecility Ck Fune	ral Home	of Dund	alk,	Inc.		
	+	23e. Pert1. Enterine disease or c shock, or heart feilure. List o	complications that cau	used the deeth.	Do not ente		se Ave.		, Maryl	and	21222 Approximata		
sician		shock, or helart feilure. List o	nly one ceuse on eac	ch line.		300 011	War and The Control				Interval Between Onset and Death		
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miner		resulting in deeth)	а	Due to (or	es e conseq	neuce of).	14				7.17.710.5		
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trans	Examiner	Sequentially list conditions,	Ь.		as e consequ			7					
		Sequentially list conditions, if any, laading to immadiata ceuse. Enter Underlying Ceuse (Disease or injury	CO1	onery	arte	ry dise	6:0-				Years		
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ched	Physici	Pert II. Other significant condition	s contributing to deal	th but not result	ting in the un	iderlying ceuse g	iven in Part I.		tobacco usa co				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 10,10 P.M MORRIS VAUGHTERS 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1310 N. LINWOOD AVENUE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 MD 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 13-58-4784 Usual Residence of Decedent Vre 48 Director 10e. State 10b. County 10c. City, Town or Location 10d. fnside City Limits or 28a-f show must be notified at 1 Ves 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1310 N. LINWOOD AVENUE 21213 "natural", or items 23a death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglena. Important: If item 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Exemples. DARS. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: BLACK 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 X Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SECURITY GUARD USF&G 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JOHN** VAUGHTERS GREENE JENNIE 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VAUGHTERS/FATHER **JOHN** 1310 N. LINWOOD AVE. BALTO., MD. 21213 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from State Mem PK Balto, 4⊟Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC Tron 1701 LAURENS ST BALTO. MD 234 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiomyopath Examiner Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. attending physician for use as the buria that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records. 2 icate has been sign, page 2 should b 24b. Were autopsy lindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Aftar 1 Naturai 5 Pending s efter deau. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide • Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospi within 24 hou To the Funer complately fil

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Division of

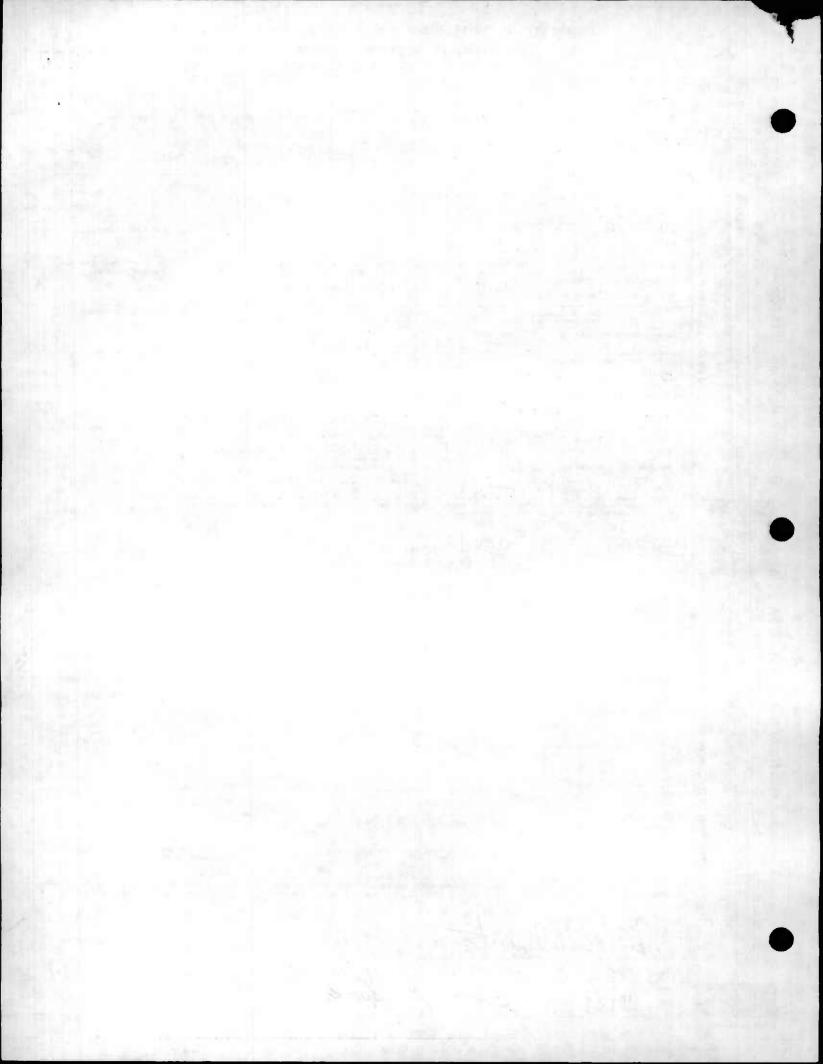
State Registrar 29b. Signature and title of certifie

MICHAER 31. Date filed (Month, Day, Year)
MAY 3 1 2 MARTIN 32 Registrar's Signature

30. Name and address of parson who completed cause of death (Item, 23a) (Type, Print) Belair Rd.

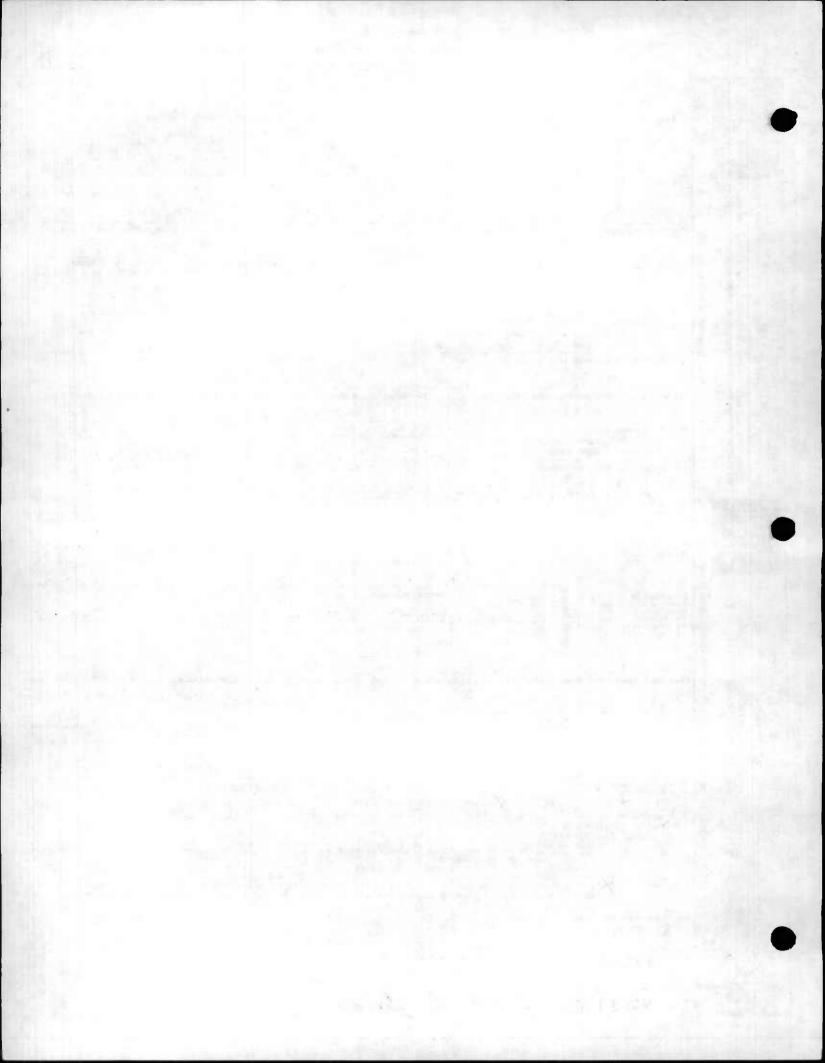
29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year 4-14,0x Physician Barbara Maria Werner 30 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltonorp col Balkwar 1+5 yeshed Hours Min. 6. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex **Funeral** Days 1 M 2 K Yrs. 217-50-8189 Director Dec. 30,1946 Germany **Usual Residence of Decedent** 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 No ms 23a or 23a-f a Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 United States 2903 North Calvert Street 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Berral. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Book Editor Medical permit. Pages 1 and 2 ahould be file.
Department of Health and Mental Hygin important: if them 27 is marked and injury or other. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be 2 Joseph Werner Louise Severan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) Jerzy Werner (Brother) 976 Regina Drive Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/31/00 Catonsville, MD Metro Crematory, Inc. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that baused the a shock, or heart failure. List only one cause on each ine. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ocardered Enforction Examiner Doe to (or as a consequence of): Physician/Medical Examiner AYDOXICA physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, metystatio Ovcerace Due to (or as e consequence of): P.O. signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were sutopsy findings svailable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 DINO 1 ☐ Yas 2 ☐ No Vital To the Hospital or Atlanding Physician: within 24 hours after death.

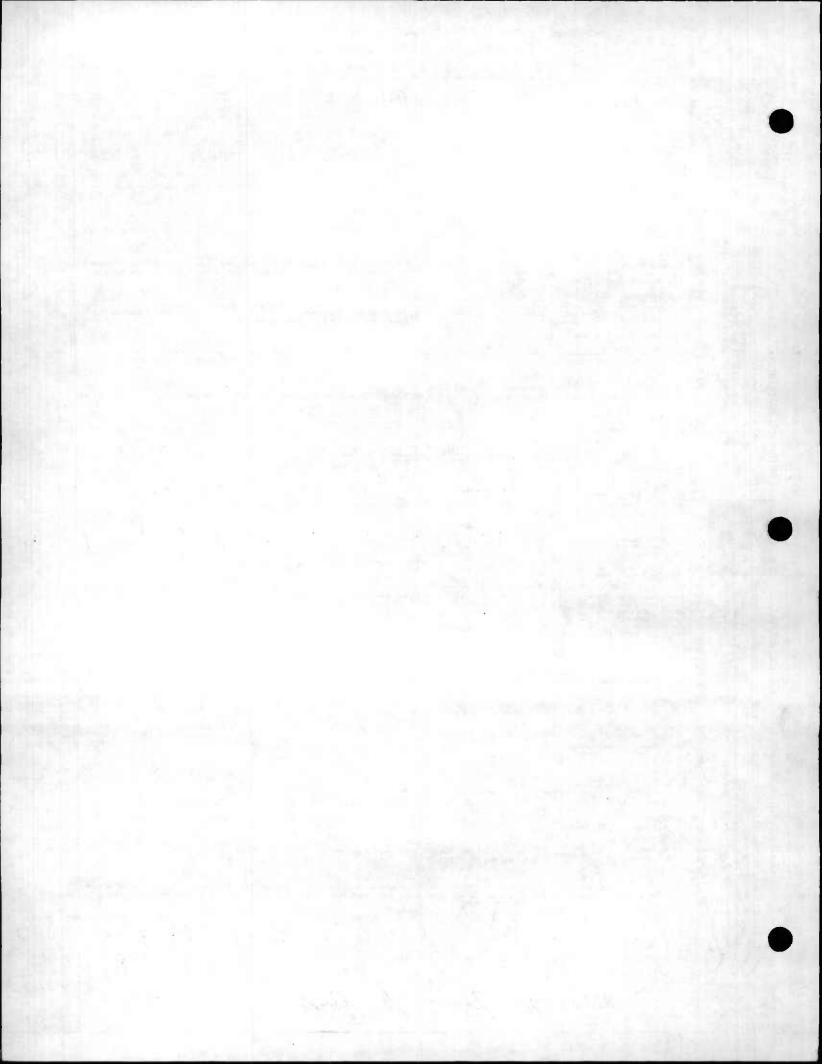
To the Funeral Director: After this certifical completely filled in by the funeral director; I 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2€ No o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30 Res-000 2000 30. Name and add retitled cause of death (Item 23a) (Type, Print) ess of person who co 9005 Schwarz Sma 31. Date filed (Month, Day, Year) 32. Registrar's Signatuge MAY 3 1 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death K. WALLACE Day Year Physician PM 3abe 8:09 05 -/Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner STREET BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-20-38 5. Social Security Number Birthplace (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Months Days 518-48-3774 Usuel Residenca of Decedant Yrs. Director 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director MD NIA BALTIMORE 28a-t 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b than "natural", or items 23a the Medical Examiner must b 4015 STREET 21225 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Stetus Black, White, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry UK 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed to Department of Health, and Martal Hygien important: If fem 27 is marked other th, any filury or other traumatic event, the otics. 9TH GRADE CLERK NA 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be WILLIAM PULLIN KATHERINE BEAVERS 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) LOTH! GRACE CATON SISTER STREET MO 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cramation 3 ☐ Removel from State METRO CREMATORY 4 ☐ Donation 5 ☐ Othar (Specify) 05.31.00 BALTIMORE, MD 22. Name end Addrass of Facility 21. Signature of Funerel Service Licenses CREMATION SERVICES 5151 BALTO. NATL' PIKE, BALTO, MD. 21229 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or near failure. List only one cause on each line. Approximete Intarval Between Onset and Deeth **Physician** Immediata Ceusa (Final disease or condition resulting in death) /Medical ear Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physicien end for use as the burial-transit Sequentially list conditions, if eny, leading to immedieta cause. Enter Underlying Cause (Disaase or Injury Dua to (or as e consequence of): Records, P.O. Box 68760. that initieted events resulting in death) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 8 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificeta Division of Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) axaminar? 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred edicai Certification: the Hospital or Attending Ihin 24 hours after death. Neture 5 Pending investigation 1 Yes 2 Accident Director: within 24 hours after dea To the Funeral Director 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homleide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Cartifier 29b. Signatura end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 30. Name and addrass of person who completed causa of daeth (Item 23a) (Type, Print) Ce YATR 31. Date filed (Month, Day, Year) MAY 3 1 2/224 32. Registgar's Signatura

DHMH 16 Rev 6/95

State Registrar



Piease Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 10:30 PM Year **Physician** HELEN HAVES WILSON 05 - 29 - 00 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2317 EDMONDSON AVENUE BALTIMORE NIA | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Y 08 - 13 - 0 5. Social Security Number Birthplaca (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F 216-20-5633 Usual Rasidence of Decedant Yrs. Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director MD N BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 238 2317 EDMONSON AVENUE USA 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yas 2 No 1 Never Married 2 Married 1□ Yes 2□ No Baltimore, Maryland 21215-0020 "natural", or Specify: If Yes, Give Yaar or Datas: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 TH GRADE SCHOOL TEACHER DEPT. OF EDUCATION 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) and 2 should be it seath and Mental H m 27 is marked off Be DOUGLAS WAKINS JANETTA DAVIS 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2-1 Department of Health at Important: If Nem 27 is any Injury or other trau GRESHAM SOMERVILLE 2317 EDMONSON AVE., BALTO. MD. 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stata ARBUTUS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 106.02.00 BALTO. MO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE aus 5151 BALTO. NATE PIKE BAUTO. MO. Approximate Intervat Between Onset and Death 23a. Part1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition rasulting in death) /Medical 2 mos Examiner Due to (or as a consequence of): Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Dua to (or as a consequence of): 8 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 thknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 TYas 2 No 1 □ Yas 2 □ No Vital 25. Was case refarred to medical 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Aesidence 6 Other (Specify) 1 Yas 2 No to P. 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Neturat 5 Pending invastigation 1 Yes 2 No 2 Accident or Attendation of the Court 6 ☐ Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Program 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signatura and little of certific 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 828 W. 5 Haw St. Balto Mol 21201. obart Lirwin und

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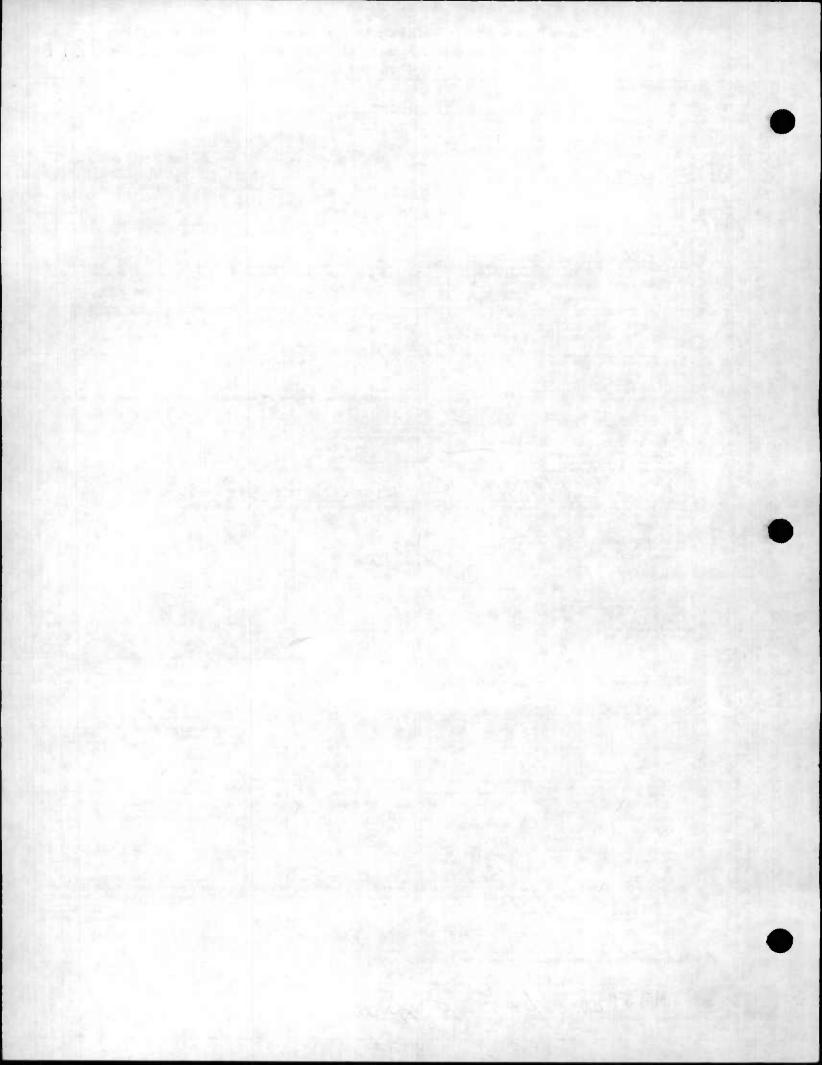
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32. Registrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene U

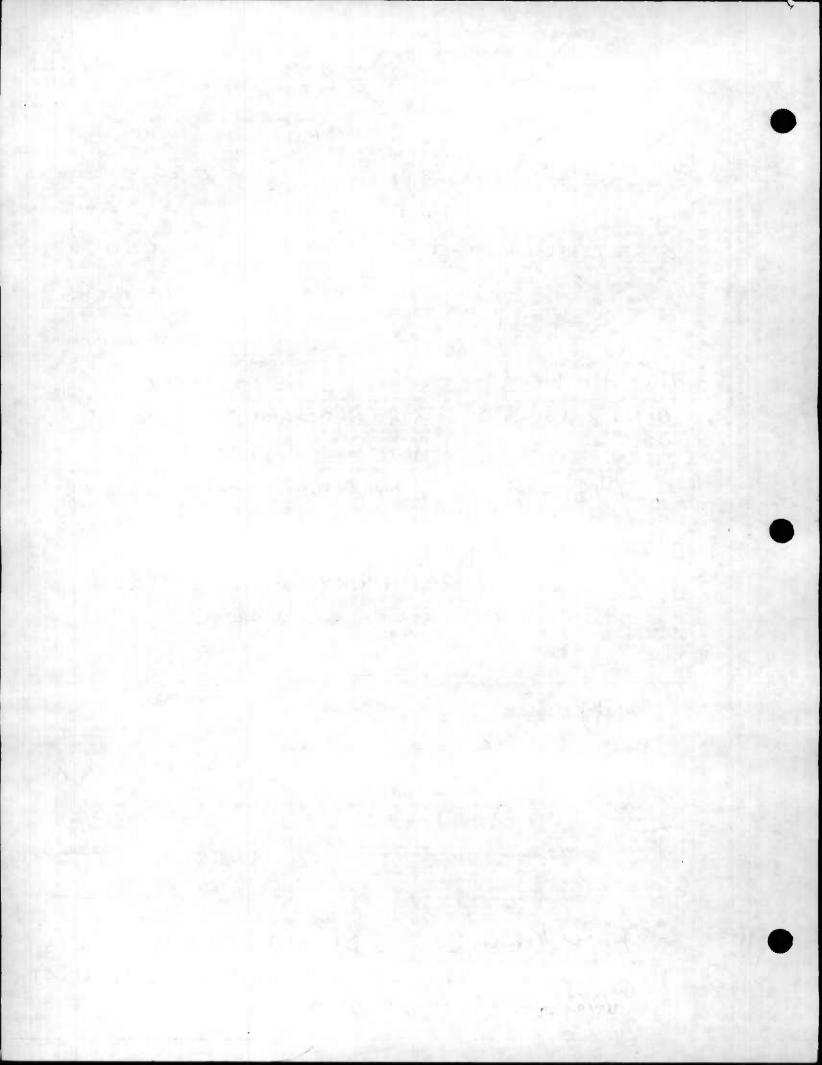
Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** May 27, 2000 5:40 PM Frank Wiggington Thomas /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner Genesis Elder Care - Hamilton Baltimore City N/A If Undar 1 Yaar If Undar 24 Hrs. Hours | Min. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign 8. Data of Birth (Month, Day, Year) **Funeral** Hours Days Months 1 M 2 F Director 87 215-05-8452 July 4, 1912 Maryland the Maryland 10a Stata 10b. Count 10c City Town or Location 10d. Insida City Limits th and Mental Hygiene. 7 is marked other than "natural", or fisma 23a or 28a-1 ahov traumatic event, the Medical Examinar must be notified at 1 ¥ Yas 2 □ No Director Maryland N/A Baltimore City 10e. Street and Number 10f. Zio Coda 10g. Citizan of What Country? 4217 Hamilton Avenue 21206 U.S.A. Funeral 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) filed within 72 hours after 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No WW II Specify: White 21215-0020 1 Yas 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grads completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) 7 VY ¹ S Collega (1-4or 5+) yr's Maintenance Dept. Baltimore City Schools Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) . Peges 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Be Wilbert Unknown Wiggington 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guretta Wiggington - Wife 4217 Hamilton Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) **Department** 4 Donation 5/31/00 Towson, Maryland Hilltop Service
22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licens Baltimore, Maryland 21214 au Kalboch Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part 1. Enter the disease, or complications that cause of latest the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical Month Examine Dua to (or as a consequance of): Physician/Medical Examine Sequentially list conditions, if any, leading to Immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest attending physician and for use as the buriat-tren Dua to for as a consequence of): Box 68760. Dua to (or as a consequence of): P.O. Part II. Other elgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. ð The tew requires 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? page 2 s 1 Yas al No 1 □ Yas 2 □ No of Vital Be 25. Was casa rafarred to medicel axaminar? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 1 Yas 2 No 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) Certification: To this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Daacribe how injury occurred To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Division 1 Natural
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2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. Licansa number 29d. Date signad (Month, Day, Year) 29b. Signature and title of certifie 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) Μ. Rahnama, M.D. 6730 Holabird Avenue 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar



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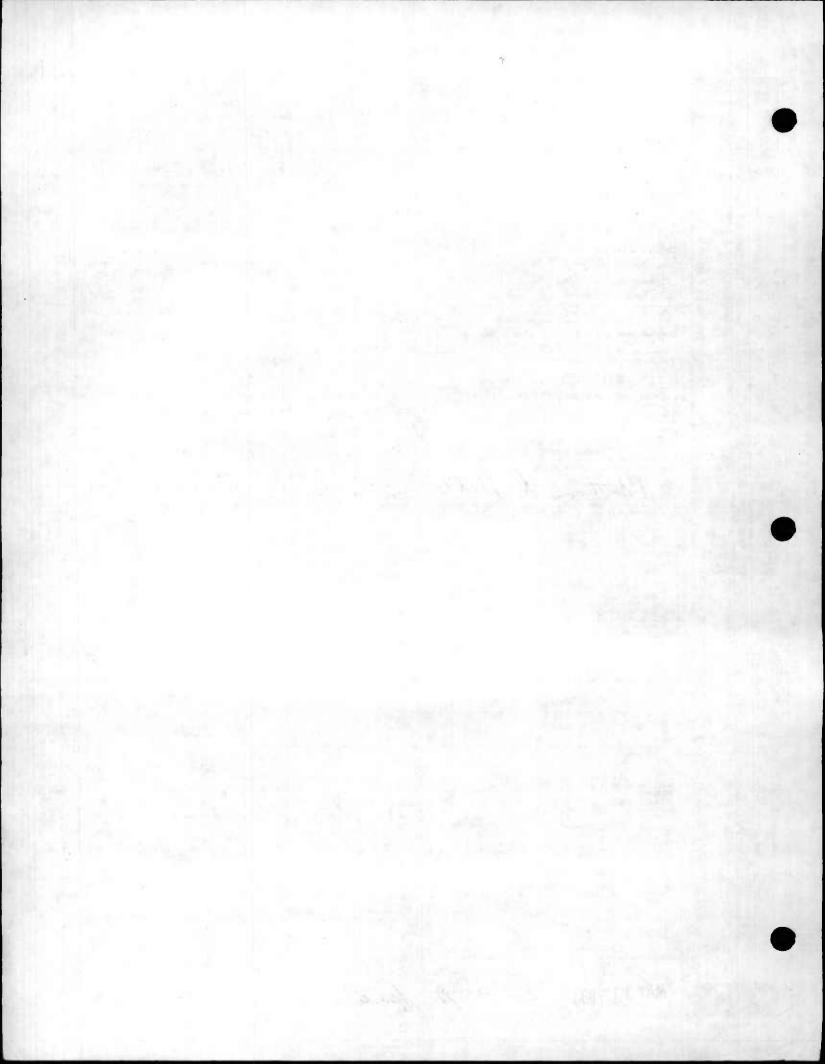
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** JOSE PH WARD Just /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bahtimore DECOUR If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 12M 2DF Months Days 243-20-5394 North Corolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or Itama 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore 1 Yes 2 No Funeral Director MARyland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 2323 21216 and Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. 11 Marital Status 1 Yes 2 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Montgomery COOK 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Department of Health and Mental Important: If Item 27 is marked o PERRY hurston LEONA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 Artense 2323 DukeLand Street 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 6/2/2000 Balto. Co. MD. Western Star Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Millers Meter. Chapel P.C. Balto. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Arterio Venous The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Endstate 10
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Ineral Director: After this certificate by filled in by the funeral director, pa 25. Was case referred to medicel examiner? Medical Certification: To Be 26. Place of Deeth (Check only one) Hospital: 15 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 20 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital C ure 24 hours a use Funeral C 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name and eddress of person why completed cause of deeth (Item 23a) (Type, Print) Mog 4660 remarram 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State MAY 3 1 Registrar



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Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Athero Sclorchc heart disease or conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Inderlying Cause (Disease or Inderlying Cause (Disease or Inderlying Cause. Enter Underlying Cause.		shock, or he	art feilure. List	only one cause of	n eech line.	Joans, Do not entit	or the mode or dy	ng, soci as cardiec	or respiretory of	anost,		Intervel Between Onset and Deeth	
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1 Yes 2 No		examine?								h (Check only one)			
27. Manner,of Death Month, Dey Year) Manner,of Death Month, Dey Year) Month, De			No	Hospital:	Macaital: /								
29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner es stated.	:u			28a. Dai									
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 1	5	bulluling, etc. (Specify)							City of Town, Stelle)				
	5	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated.									ated.		
	2		2 Medical E	Examiner: On the	basis of exam	nination and/or inv	restigation, in my	opinion, deeth occu	rred et the time	, date and ple	ece, and due to	the ceuse(s)	
29c. License number 29d. Dete signed (Month, Day, Year)		29b. Signature and	d title of partition	/			29c. Licens	se number		29d. Dete si	igned (Month, E	Day, Year)	
030494 =10012000		•	A				0.2	OHAH		=100	212000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NESAI MY Death Medical Control 611 South Charles street Baltimore MD 210	- 8	D30494 518912											

ORIGINAL



00-2887-031 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. j hm State of Maryland / Department of Health and Mental Hygiene DONALD Certificate of Death WEINEL 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dev Year Month **Physician** Donald Cay Weinel MAY 24, 2000 /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner KUCKVILLE SHADY GROVE ROAD MONTGOMERY If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Sacurity Number Dete of Birth (Month, Dey, Year) **Funeral** Deys Hours 128 M 2□ F Yrs. Director 486-64-0320 47 1953 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Berns 23s or 28s-f show Directo idical Examiner must be notified MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5423 Chatterbird Place 21045 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? be filed within 72 hours after 1 M Yas 2 No If Yes, Giva Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married ò Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 Construction Worker W. F. Wilson & Sons 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surnema) Be and Mental Cay G. Weinel, Jr. Jeanne A. O'Brien 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If them 27 is n Cay G. Weinel, Jr./Father 5423 Chatterbird Place, Columbia, MD 21045 altimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crametory or other place) Dete 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State à Meadowridge Memorial Prk 5/27/00 Elkridge, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Nema end Address of Fecility Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, MD 21045 0 demmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner Sequantielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initieled events resulting in deeth) Last the burial-tran Due to (or es a consequence of): attending physician Box 68760 Physician/Medicai Dua to (or as a consequenca of): 80 signed by the atte 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown þ Completed

The law requires that the death certificate be executed of Vital Records, P.O. peed has page 2 certificate Physician: this funeral After Division Attending ours after dean our Director: An in by the fire

To the Hospital or within 24 hours at To the Funeral D

24b. Were autopsy findings evailable prior to 24a. Was en eutopsy performed? complation of causa of death? Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) construction Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2□ No 1 Inpatient 2 ER/Outpetient 3 DOA 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Neturel 11:54 AM 1 Yes 2 □ No 5/24/00 2 Accident Subject crushed by macifine 6 Could not be determined 281. Location (Street end Number or Rurel Route Nur City or Town, Stete) SHADY GROVE RUAD 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide CALABASH CONTRUCTION SITE ROCKVILLE, MD

edicai 29a. Certifier (Check only one)

Be

2

Certification:

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2. Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

OCME

29b. Signature and title of-certifier

29c. Licensa number 29d. Date signed (Month, Day, Year)

MAY 25, 2000

3. Time of Death

10d. Inside City Limits

White

Approximete Intervel Between Onset end Deeth

1 ☐ Yes 2 No

11:57 AM

30. Neme and address of rson who completed cause of deeth (Item 23e) (Type, Print) MiD

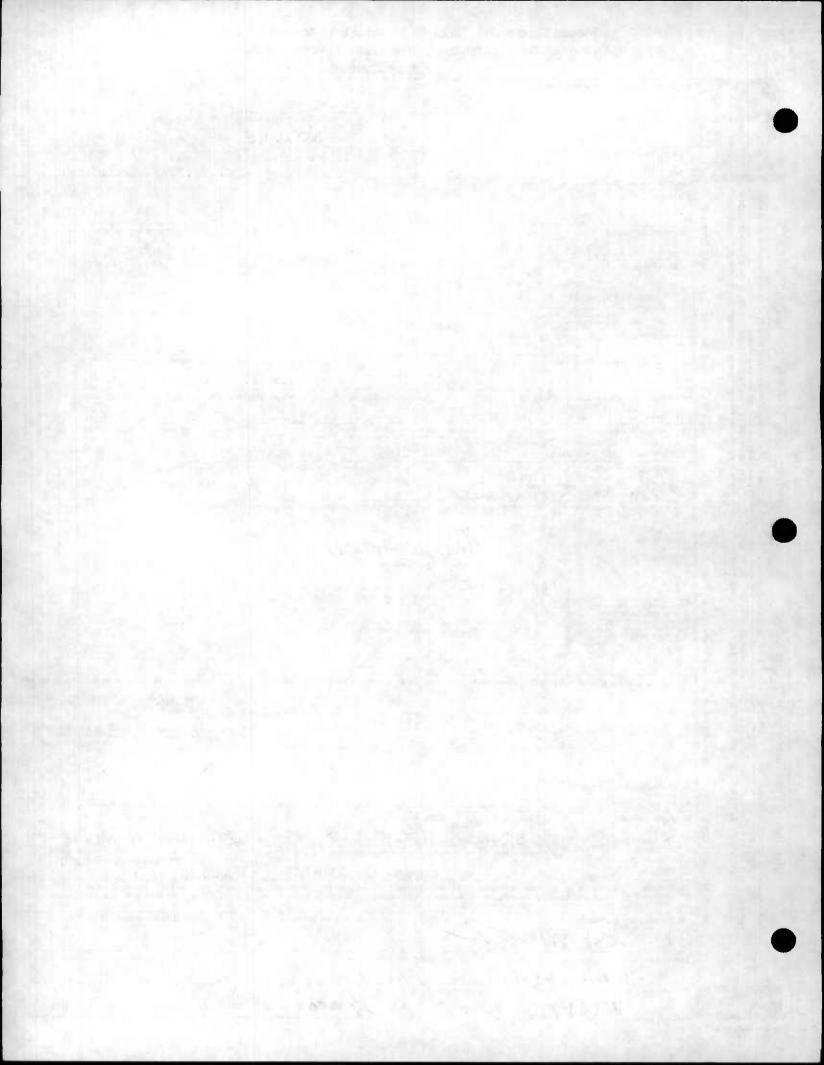
111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year) MAY 3 1

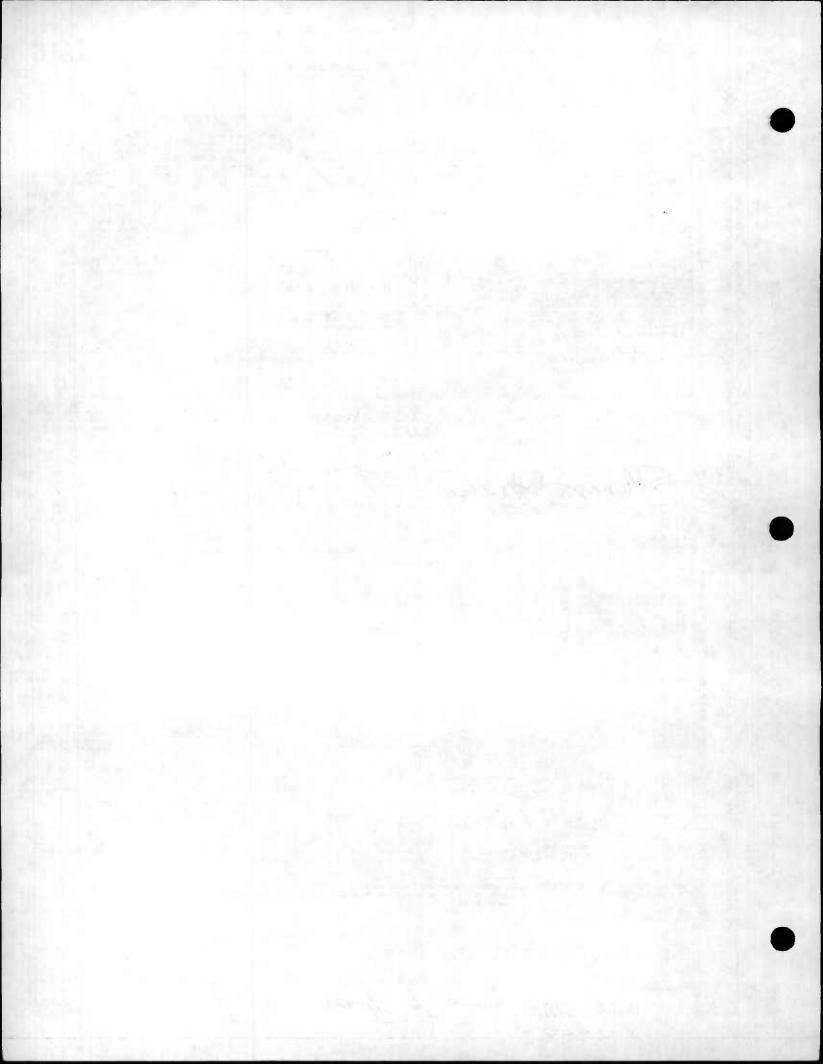
TACK M.



Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 17215

					Cen	tificate of	Death			Reg. No.	0	1/2/3	
hysician	1. Decedent's Name (First,			2. Deta of De- Month	ath Day	3. Time of Death							
/Medical	war				mak	25, 25	Year JUD	12:40 A					
xaminer	4e Facility Name (If not ins	stitution, giva	street and number)			4b. City, To	wn, or Loc	ation of Death	4c. County	of Death		
	Northwest	Hosp:	ital						stown		ltim	ore Co.	
neral	5. Social Security Number	6. Sax	x 7. A	ga (In yrs. las		If Under 1 Yaar Months Days		24 Hrs. Min.	8. Date of Bird (Month, Da	h y, Year)	9. Birthe	placa (Stata or Foreign ntry)	
ector	217_28_34		Am 201	65	Yrs.				02 0		M.		
				10c City 7	Town or Loc	ation					1.	10d. Inside City Limits	
thems 23e or 28e-f show instrument be notified at Funeral Director												1 1 Yas 2 □ No	
	MD NA Baltimore											••	
ă	10e. Street and Number					10f. Zip Code				10g. Citizen of	What Cou	ntry?	
Funeral	3411 Flan	nery I	Lane			212	07			U.S	.A.	can Indian,	
Š	11. Marital Status		12. Was Decedant Armed Forcas	?	13. W	as Decedent of Yes, specify Cub	Hispanic On an, Maxican	gin? (Spec n, Puarto R	city Yas or No lican, atc.)	Bla	ck, Whita,		
by F	1 ☐ Navar Married 2 ☐ 3 ☐ Widowed 4 ☐ Dh		1 Yas 201	No	1	Yes XXNo	Specify:			Specif			
			Year or Detas:		16a Dagade	atta Haual Ossu	nation			16b. Kind of B	Bla		
Completed	(Specify only	cedent's Edu highast grade	a complated)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)					TOD, KING OF B	usinessin	dustry	
E	Elemantary/Secondary (0-12)	Collega (1-4or	5+)	Construction Worker					Cent	av C	ompany	
Ö	9th grade 17. Fathar's Nama (First, A	fiddla. Last)	na		COM	CEUCLI	1			Maiden Suman		Ompany	
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70	Howard Wat 19a. Informent's Name/Ra		ma Brintl		40h Mailine	Addrass (Stree			Munfor		Ctata Tie	Codel	
												00000	
	Rachel L. 20a. Mathod of Disposition	Water	rs-Wife	20h Plac	3411	Flann	ery I	lane	, Bal	20c. Location		21207	
	to Burial 2 □ Cram	ation 3 🗆 R	amovel from State	com	atary, crem	atory or other ple	ece)		Data	200. Location	City or Te	own, Stata	
	4 ☐ Donetion 5 ☐ Ot			Kin		orial			31/00	Randa.	llst	own, Md	
2000	21. Signaturn of Soneral S	ervice License	2	-	M a	Neme and Addr	ass of Facilit	št					
/	Mary	MO	XXX	00)		00 Wab			Balt:	imore !	Md	21215	
	23a. Pert 1. Enter the disease shock, or heart failure	or compli	ications thet cause	d tha death.	Do not enta	r the mode of dy	ing, such es	cardiac or	raspiratory a	rast,		Approximata Interval Between	
edical Examiner	Sequentially list conditions if eny, laeding to immadiat cause. Enter Underlying Cause (Disease or injury that initiated evants	S).	Dua to (or a	s e consequ								
in/Medical	rasulting in death) Lesf	L	1.	Dua to (or as	s e consequ	ence orj:		-72					
Completed by Physician/	Part II. Other significant co	onditions con	tributing to death t	out not rasulti	ng in the un	derlying causa gi	ven in Part I		23b. Did tobacco use contribute to the cause of				
Y P												4	
P									24a. Was	an eutopsy	24b. W	ere autopsy findings vailable prior to	
olet					_				perio	mear	00	ompletion of cause death?	
E									10	res 2 No	1[□ Yas 2□ No	
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	25. Wes casa rafarred to m	nedical	-				26 Place	of Dooth	(Check only o			- 100 ED 110	
	examinar?		lospital:	ant 0 E5	VOutpatient	217 DOA 01	hor				ar (Cana)	4.1	
	27. Mannar of Death		28e. Dete of Inj. (Month, De		Bb. Time of	3LI DOA 4LI NUISING HOME			oma 5 Rasidenca 6 Other (Spec 28d. Dascribe how injury occurred			(Y)	
	-V	Pending nvestigetion	(Month, De	ay Year)	Injury		rk?]Yas 2 □						
	3 ☐ Suicida 6 ☐ 0	Could not be	29a Place of In	iune At home	a form etco				8f Location /	Street and Num	her or Bun	al Route Number	
F	4 ☐ Homicide	determined	28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)					281. Location (Street end Number or Rural Routa Number City or Town, Stata)					
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	Alic	e 1	1-181			144	377	4		lagy "	tt.	C164	
	30. Nema and addrass of p	arson who co	mpleted ceuse of	death (Item 2:	3a) (Typa, P	rint)					,		
	HECE	1-151-16	NON	the	est.	1-1011	nal		Randa	Mitan	a,	hd	
tate	31. Date filed (Month, Dey,	Year)	32. Regist	rer's Signetur	ª 4	10-1	,						
istrar	MAY 3	1 2000	Dene	~~~	N.	pours							
Rev 6/95	G I HIVI	1 2000	Lora		-		•						



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #10B-D PER F.H. G783 5-31-00 Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** WRIGHT ERIC GARY 1804 ltvs MAY 25 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALISTUWN HOJPITAL RALTIMORE NORTHWEST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 M • D • **Funeral** 11XM 2□ F Months Yrs. 06 218-46-5085 Director 11 Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits T is marked other than "natural", or itema 23s or 28s-f show traumatic event, its Medical Examinar must be notified at Baltimore COLUMBIA HOWARD MD -NA 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21144 7149 Rolling Bend Rd Apt 9F Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1X Yes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effect. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "instination," or then pages. Black, White, etc. 1⊠ Never Married 2 Married 1 Yes Mo Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Security 3 Benefit Authorizer 12th grade yrs 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Helena Sawyer Timothy Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6601 Parsons Ave, Baltimore Md 21215 Helena Wright-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 5/31/2000 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service License 21215 4300 Wabash Ave, Baltimore Md Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical RESPIRATORY FAILURE Examiner Due to (or as a consequence of): edical Examiner SEPSIS attending physician and for use as the burial-transit the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PNEUMONIA Box 68760. Due to (or as a consequence of) Physician/M P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 2 No 1 Yes 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitat: 12Unpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred edical Certification: 5 Pending investigation 1 DNetural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Records, Division of Vital

DHMH 16 Rev 6/95

State Registrar 29e. Certifier (Check only one)

31. Date filed (Month, Day, Year) MAY 3 1

29b. Signature and title of certifier

RAVI MD NHC 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTO. MO 21133

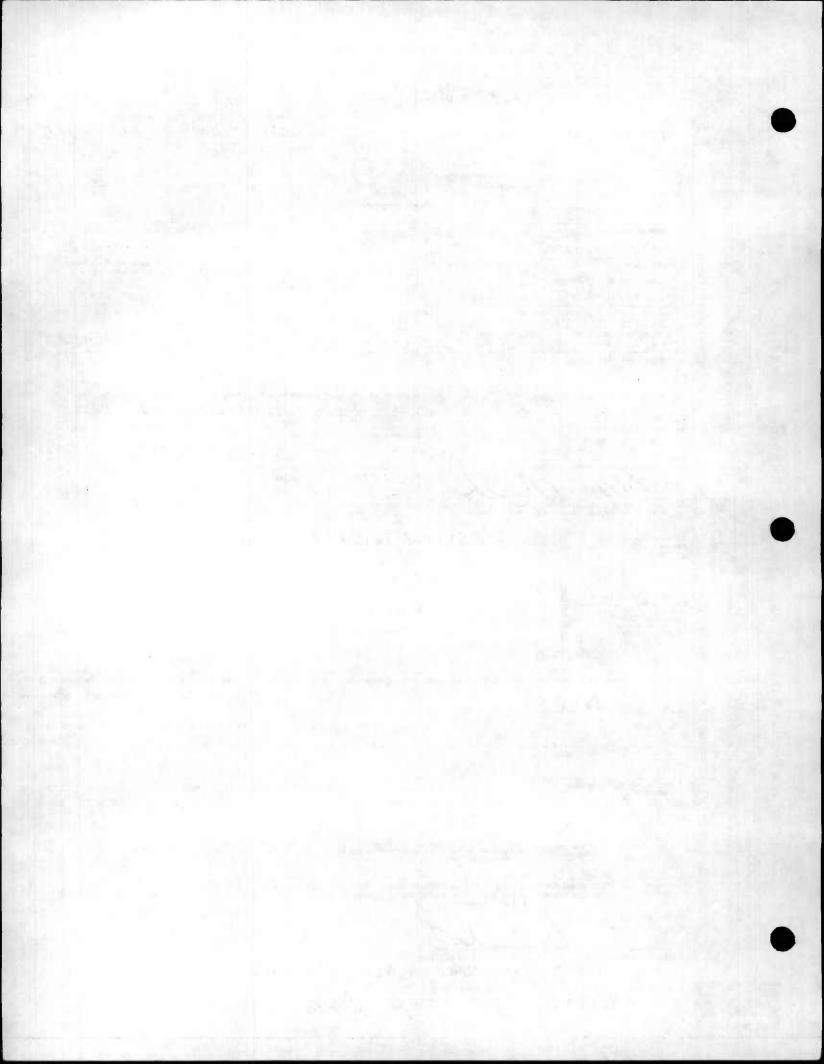
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) MAY 25, 2000

ORIGINAL



	ITEM: 10A, 19B PER F.H. G783 5-31-00 Certificate of Death 1. Decedent's Name (First, Middle, Last)									2. Dete of Dea				ime of D	eeth
ysician	Edna			Deleas	se		W	lebb		Month	Day 23	Z00	1.0	:55	P
Medical aminer	4a Facility Name (, give street an						wn, or Lo	cation of Death	4c. Co	ounty of D	eath		
	SIN		SPITAL		BALTIN			BAL							
eral	5. Social Security N		6. Sex 1 ☐ M 2 💢	IF	rs. last birthday) Yrs.	Months	Days	Hours	24 Hrs. Min.	(Month, Day	, Year)		Birthplace (Country)		Forei
ctor	226-32- Usual Residence of			80						03 24	20)	V.A.		-11
miner must be notified at	10a. State	10b. County		10c.	City, Town or La	ocation							10d. In	side City	Limi
Director	MD	Balt	imore		Pikes	ville	е			1 ☐ Yes_2				Z N	
Die.	10e. Street and Nu	0223		Level Road	i	10f. Zip							of What Country?		
la la	8223 Sc	cottsle			110 12	W D	21208 Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, e				U.S.A.			diam	
Funeral	11. Marital Status	ried 2□ Merrie	Arme	Decedent Ever in ed Forces? Vec 2/73No	0,5.	If Yes, spec	city Cuba	an, Mexicar	n, Puerto	Rican, etc.)			vmerican Inc Vhite, etc.	olen,	
ģ	3XXVidowed		If Year	Yes ANNo es, Give r or Dates:		1□ Yes	2[XNo	Specify:			S	pecify:	lack		
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Completed	Elementary/Seco	age (1-4or 5+)		kind of wo DO NOT us		d)	N OF WORKS	"9							
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	Edna Pt 20a. Method of Dis	sposition		20b	. Place of Dispo	osition (Nan	me of		- RO	Date			or Town, S		-
	Burial 2	Cremation :	3 □Removel (from State	altimo				5-	30-200	0 P=	lti	more	МА	
à	21. Signature of Fe				2	2. Name an	nd Addres	ss of Facilit	ty	00 200	• Бе	1161	more,	110	-
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ORIGINAL

Piease Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. Amended Item#19a perFHG785 7/14/2000 EState of Maryland / Department of Health and Mental Hygiene amend item 1 per phys. G785 7/7/00 yg Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Maxcine Williams intell and 2000 00 Spm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RBOR HOSPITAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) 6. Sex 7. Age (In yrs-last birthday) 8. Data of Birth **Funeral** Days 1 M 2 F Yrs Director idence of Decedant Town or Location 10d. Inside City Limits 1 Tes 2 No Director or 28a-1 10g. Citizen of What Country? or hams 23a Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 Yas 2 17 No If Yes, Giva Year or Datas: nt of Hispanic Origin? (Specify Yes or No-y Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Ifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within Elementasy/Secondary (0-12) College (1-4or 5+) ustodian oth 17. Fethar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be 1 and 2 should be Health and Mental permit. Pages 1 and 2 a. Descriment of Health and Important: If Item 27 is ma any Injury or other in-Informant's Name/Ralationship (Type, Print) 20a. Mathod of Dispositi 1 Burial 2 Cremetion 3 Ramoval from State 4 Donation 5 Othar (Specify) ng, such as cardiac or raspiratory arrest Approximata Intervel Between Onset and Deeth ha efsaasa, or complications that caused tha daath. Do not entar tha mode of dy ert feilure. List only ona cause on each line. **Physician** Immediate Causa (Final diseasa or condition rasulting in deeth) /Medical 5 day Examiner Physician/Medical Examiner SCHEMIC CARDIOMYOPA burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury Dua to (or as a consequence of): Box 68760. that initiated events rasulting in death) Last Dua to (or as a consequence of) the P.O. | signed by the a Pert II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown HEMIPLEGIA, MULTIANFARCT Records. Be Completed by 24b. Ware autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? DEMENTIA, DIMBETES MELLI 1 Yas 2 No MYPERTENSION 21 NO certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical etely filled in by the funeral director. E 25. Was case rafarred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 15 Unpatient 2 ER/Outpatient 3 DOA 1 Yas MINO Other: 4□ Nursing Homa 5□ Rasidence 6□Othar (Specify) Certification: To 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 28a. Plece of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifiar TEL Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated. Medical To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. To the To the To the F 29c. License number 29d. Data signed (Month, Day, Year) 2000

DHMH 16 Rev 6/95

Registrar

CENTER, 3001 S. HANOVER, BALTIMORE MD

21225

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

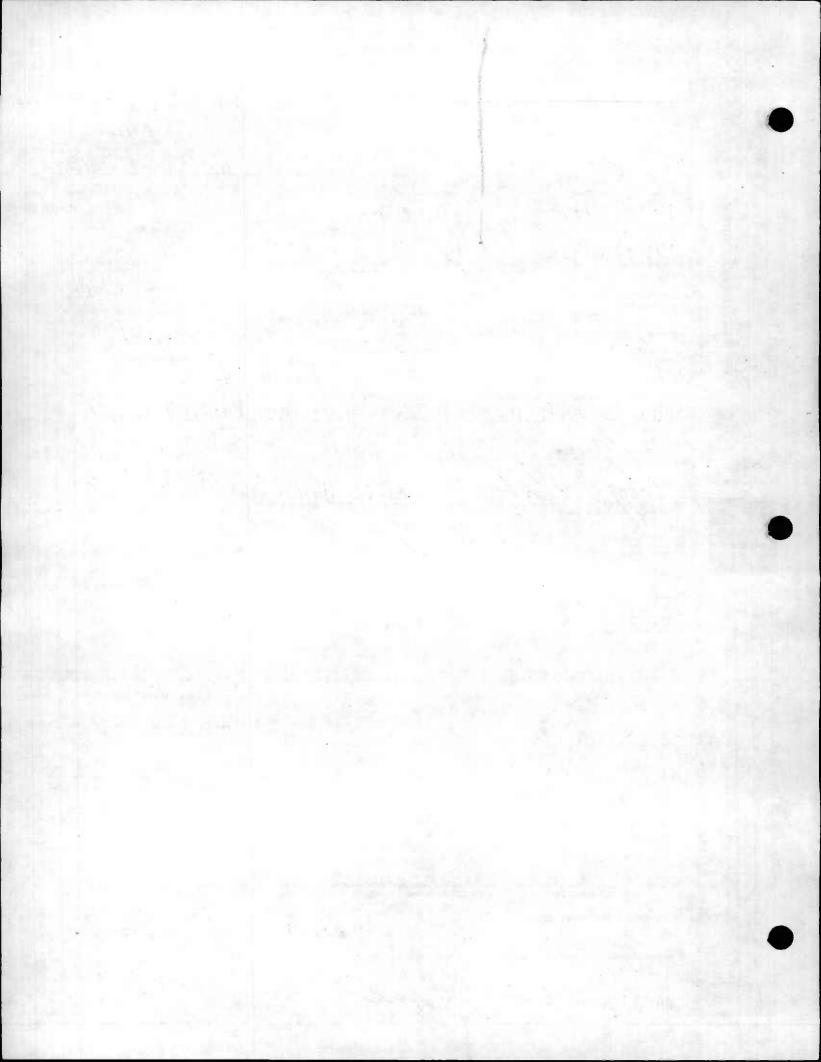
HARBOR HOSPITAL

32. Registrar's signature

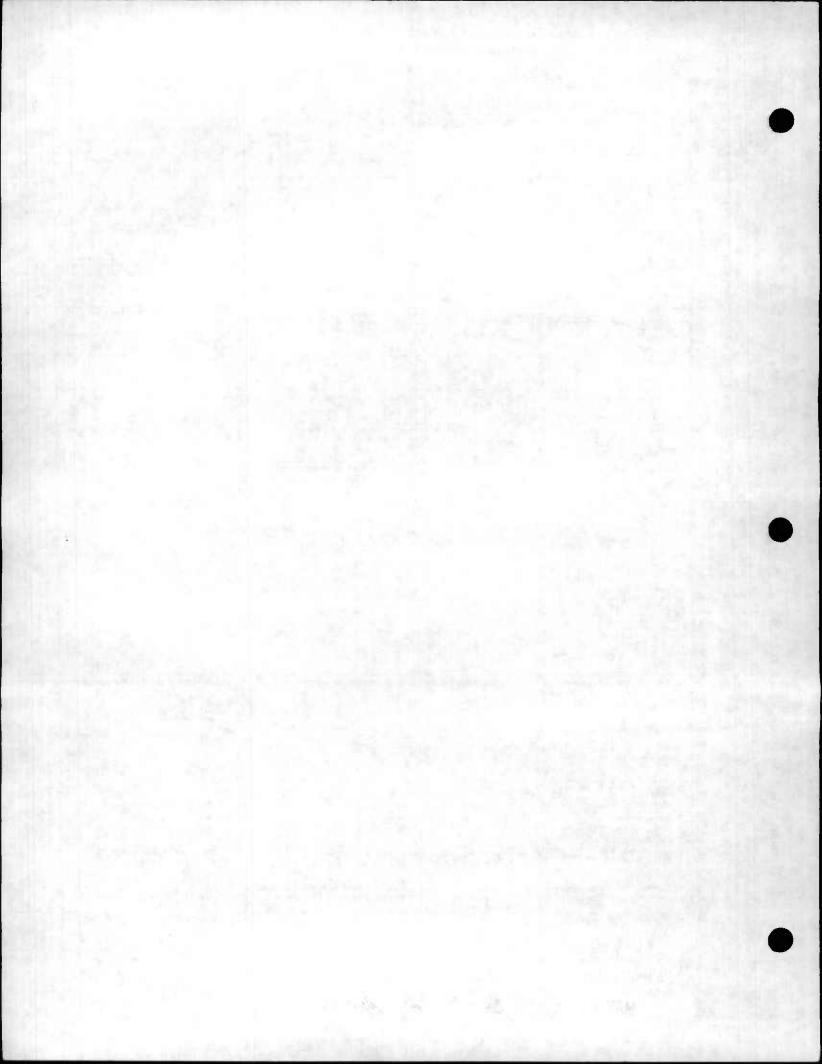
SUNLA RAPKO

31. Data tiled (Month, Day, Year)

MAY 3 1 2000



ian	1. Decedent's Na	me (First, Middle, L			W. Sala	1000		2. Date of Dea Month	th Day	Year	3. Time of Death
icat			ve street end number)			4b. City, Town, or L		0450 AM		
ner			LVERT STRE		4th f1	r	BALTIM	ocation of Death 4c. County of Death N/A			
	5. Social Security unk		Sex 7. A		est birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day June 1,	Year) 1951	9. Birthplac Country	e (Stete or Foreign) unk
	Usual Residence	of Decedent		10c City	, Town or Lo	cation				10d	. Inside City Limits
Director	MD	N/A			Balti	more		1			Yes 2□ No
			Stroot ht	h flr		10f. Zip Code	200		10g. Citizen of \		7
era		unk	12. Wes Decedent	Ever in U.S	S. 13. V		. 202 Hispanic Origin? (Si	pecify Yes or No-	US.	A ce - American	Indien,
11. Marital Status U 1 Never Married : 3 Widowed 4			Armed Forces? 1 2 Married 1 Yes 2 No If Yes, Give			If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:			Specify	ck, White, etc y: bla	
200	/Sn	15. Decedent's Education (Specify only highest grade completed)				lent's Usuat Occu	pation during most of wor	kina	16b. Kind of B	usiness/Indu	stry
Completed	Elementary/Sec		College (1-4or	5+)	life. L	OO NOT use retire	ed)	, ing			
		e (First, Middle, Las	unk		unk		18. Mother's Nam	o /First Middle	un]		
	unk	o (1 1131, IVIIOGIO, LES	•				unk		walder Surrell	110)	
-	19e. informent's	Name/Relationship	(Type, Print)		19b. Maitin	g Address (Stree	t end Number or Ru		r, City or Town,	Stete, Zip C	ode)
	O.C.M.E.				111	Penn St	reet Bal	timore,	MD 21:	201	
	20a. Method of Di		7D	CE	ace of Dispos	sition (Neme of netory or other ple		Date	20c. Location -	City or Town	, Stete
		5 1 Other (Special	□Removal from State ify) in stat								
	21. Signature of	heral Service Lice Conald S	Wade, Di	ector	22	Name and Addr State A: Baltimo:	natomy Boars MD 2	ard 655	W. Balt	imore	Street
	23a. Part1. Enter	the disease, or con	nplications that cause y one cause on each	d the death	. Do not ente				rest,	A	pproximate iterval Between
	13/2				BROSIS	AND FAT	TY LIVER	COMPLICA	TED BY	Ö	nset and Death
	Immediate Cause disease or condit resulting in death	ion	a		ERTHER						HALL STATE
	Tesuring in death	,		Due to (or	as a conseq	uence of):					
CABILLICI			b	D /	120 2 2222				A		
	Sequentially list of if any, leading to cause. Enler Und	immediate		DUO (OI	as a conseq	uence or):				1	
	Cause (Disease of that initiated even resulting in death	or injury	C	Due to (or	es a consequ	uence of):					
	resulting in death	Last									
			d							1	
Linysiciallymedi	Part II. Other sign	ificant conditions	contributing to death	but not resu	iting in the ur	nderlying ceuse g	iven in Part I.	23b. Did t	obacco use co	intribute to ti	ne cause of death?
	SCHIZ	OPHRENIA						101	/ss 2□ No	3 Proba	bly 4 ☐ Unknown
								24e. Wes	en eutopsy		autopsy findings
								репо	med?	comp	able prior to pletion of cause ath?
								181	es 2 No	10	res 2□ No
	25. Was cese refe	erred to medical					26. Place of Dea	ith (Check only o	ne)		418
	examiner? XX Yes 2	□ No	Hospital: 1 Inpat	ient 2 1	ER/Outpatien	t 3 DOA	ther: 4 Nursing H	ome \$QQResid			
	27. Manner of Dea	ath 5 Pending	FOUND:	ury ay Year)	FOUND	W			ow injury occur IVIRONMI		DIN A VE
	2 XAccident 3 ☐ Sulcide	investigetion 6 Could not i	00		4:40		Yes 2∭No				Pouto Alumbar
	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)					DENCE	211	28f. Location (S City or Tow			
	4 1 10 1110 101		hysician: To the best	of my know	viedge, death	occurred et the t	ime, date end plece	, end due to the	ORE, MA	enner as stat	ed.
ical Certification:	29a, Certifier (Check only	1☐ Certifying Pi	miner: On the basis (teted							
edical	29a, Certifier (Check only one)	Medical Exa	and manner s	tatou.		20a Lines	an aumhar		and Data siens	d Manth D	w Vocal
	29a, Certifier (Check only	Medical Exa	and manner s	iatou.			C.M.E.	E-MAN	29d. Dete signe		
Medical Certification:	29a. Certifier (Check only one) 29b. Signature en	d title of certifier	and manner s			0.	c.M.E			od (Month, De	



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7

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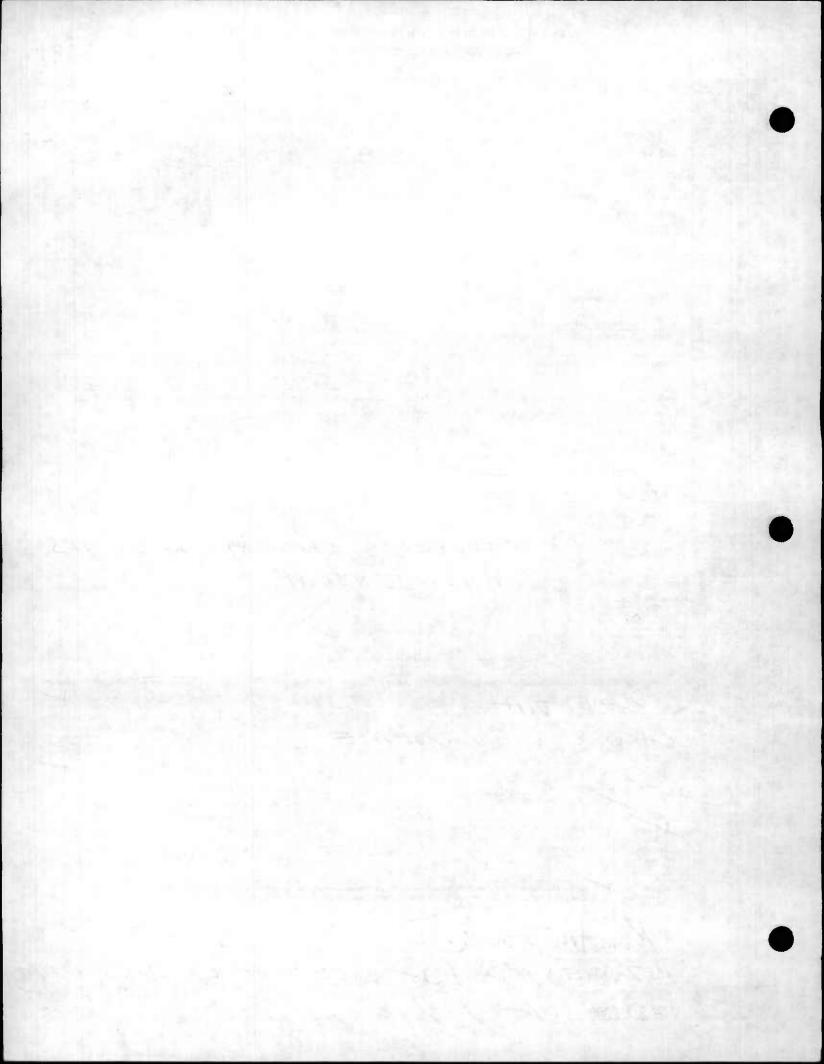
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State of Maryland / Department of Health and Mental Hygiene 00 1722

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Veer **Physician** YOUNG HELENE 15:25 DORIS MA-2000 26 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE BALTIMORE SAMARITAN CITY HUnder 24 Hrs. 8. Date of Birth Hours Min. April Pey, Gear 924 Mary land If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** Days Months 1□M 2♥F 76 Yrs. Director 216-16-3343 Usual Residence of Decede with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ns 23a or 28a-f show TY Yes 2 □ No Director Maryland Baltimore Overlea 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 21206 USA 201 McCormick Avenue Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien Black, White, etc. . Was Decedent Ever in U,S. Armed Forces? or items 11. Marital Status Peges 1 and 2 should be liled within 72 hours after 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes Specify: Specify: White þ 3€NVidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Food Service Waitress 9 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Department of Heelth end Mentel Important: If item 27 is marked of any injury or other traumatic eve Goldie Sullivan Wisner James 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice Chalfante Daughter 5410 Friendly St. Cocoa, Florida 32927
Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cametery, crematory or other plece) 20a. Method of Disposition X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 ☑ Other (Specify) Crest Lawn Memorial 5/30 Sykesville, MD 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPS IS MONTH disease or condition resulting in death) Examiner Due to (or as a consequenca of) The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as e consequence of): for use 23b. Did tobacco usa contributs to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown IMFARCTION Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed FAILURE MESENTERIC 15 CIT EMIA of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred or Attending 1 Naturat 2 Accident Division 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifie 26 2000 odoo 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MAHAEL 5601 LOCH RAVEN

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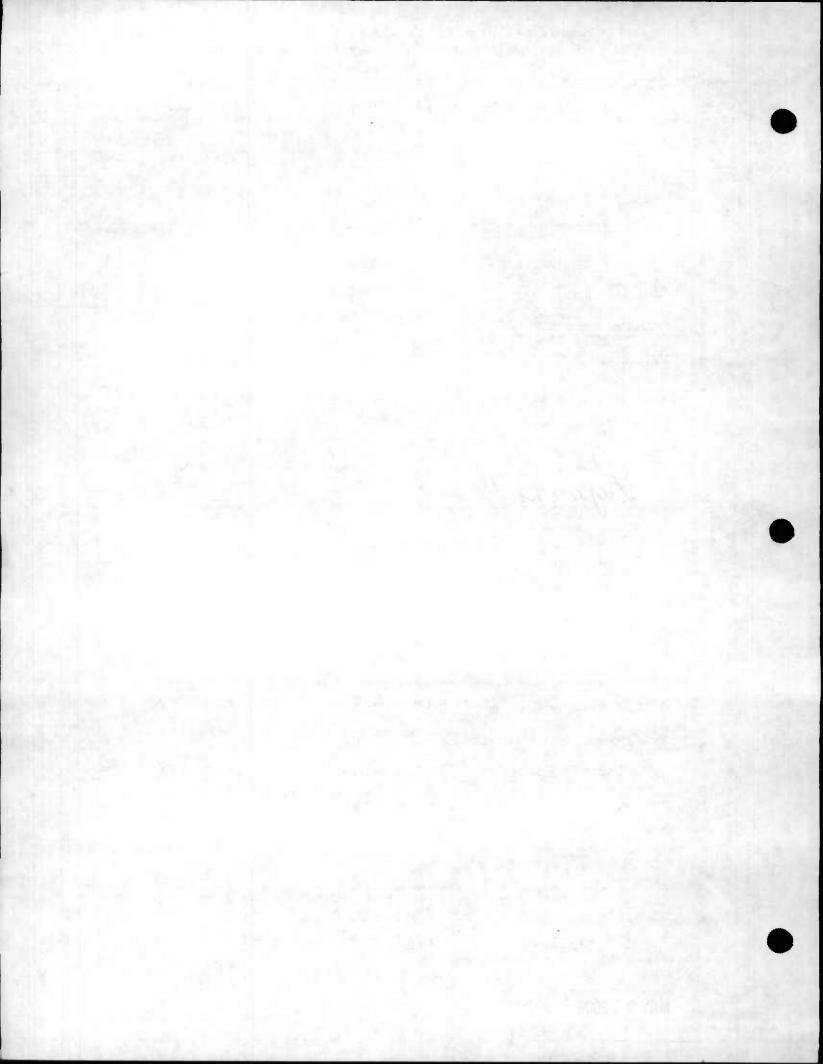
State

Registrar

31. Dete filed (Month, Day, Year)

MAY 3 1 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month **Physician** Esther Alexander May 16 2000 0138 Lenora /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth | 9. Birthplaca (Stete of Country) | 7.1 | Yrs. | Months | Days | Hours | Min. | June | 28, 1925 | Tennessee Harford Memorial Hospital Havre de Grace 5. Social Security Number Birthplaca (Stete or Foreign Country) **Funeral** 1 M 200F 219-14-0043 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Harford 1⊠Yas 2□No Director Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 731 West Bel Avenue Apt. D 21001 U.S.A. Funera 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian Black, Whita, atc. id be filed within 72 hours after de ental Hyglene. wed other than "natural", or Item ic event, the Medical Examinar. 1 Yes 2 No If Yes, Giva Yaar or Datas: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yas 2 No Specify: Specity: White 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Book keeper/Secretary Civil Service 12 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental William Hoops Ina Doak 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Karen Eustace (Daughter) 731 West Bel Air Ave., Aberdeen, Maryland important: If item 27 any injury or other to Baltimore, 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Spesutia Cemetery 5/20/00 Perryman, Maryland 4 □ Donation 5 □ Other (Specify) Tarring-Cargo Funeral Home, P.A. 21. Signature of Furieral Service License 23a. Part1. Enter the disease, or complications that Laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feiture. List only one cause of each line. 21001-3399 Approximata Intervel Between Onsat and Daath **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Dua to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. 100 Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the causa of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should be de 2 Be Completed 24b. Were autopsy findings available prior to 24a. Was en eutopsy parlormed? completion of cause of death? 1 Yas 2 No 1 TYas 2 TNo certificate Division of Vital or Attending Physician: funeral director. 25. Was casa referred to medical 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Affer T\ Natural 5 Pending deeth. 1 Yas 2 No investigation 2 Accident star deeth 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, streef, factory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the causa(s) and mannar as stated (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. within 2 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year)

Registrar

State

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alexander

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Ida-

Willah

62. Registrar's Signature

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
MAY 1 7 2000

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death ^{Day} 2000 **Physician** May 13, LEAH **AUERBACH** 9:35 AM. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery 4925 Battery Lane If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year)
Jun 22, 1918 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 M 2 K F Yrs. New York Director 102-03-9309 Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f show 1X Yes 2 No Director Parksville Sullivan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 455 Aden Hill Road 12768 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Raca - American Indian, 11. Marital Status Biack, White, etc. pemit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelth and Mentel Hygiene. Infortant; if them 27 is marked other than "naturel", or het any injury or other traumatic event, the Medical Exercities plate. 1 Nevar Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Bookkeeper Baltimore, Maryland 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Jennie Jacob Kulik 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7901 Springer Rd. Bethesda, MD 20817 Fran Rubin Daughter 20b. Piaca of Disposition (Name of cemetery, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/14/2000 Maspeth, NY Mt. Zion Cemetery 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility JOSEPH GAWLER'S SONS, INC. La Pura Manuel Washington, DC 20016 5130 Wisconsin Ave., NW 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediata Cause (Final disaase or condition rasulting in daath) /Medical Congestive Heart Failure Years Examiner Due to (or as a consequence of) Physician/Medical Examiner Severe Pulmonary Hypertension Years lew requires that the death certificate be axecuted ettending physicien and for use as the bunal-trans Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. Atrial Septal Defect Life Long that initiated events rasulting in daath) Last Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown Cancer of the Pancreas Records, 2 8 24b. Were autopsy findings available prior to completion of cause of death? nge 2 should ompleted 24a. Was an autopsy peed : 1 Yes 2 No 1 ☐ Yas 2 ☐ No Mas casa referred to medical 26. Place of Death (Check only one) Division of Vi* To the Hospital or Attanding Physicie within 24 hours after death.

To the Funeral Director: After this cer completely filled in by the funeral director. Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2N No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred t XNatural 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homleida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and till of certifier 29c. License number wear D16857 May 16, 2000 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) Washington, DC 20037 2141 K Street, NW #206 Stuart F. Seides, MD

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

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Registrar's Signature

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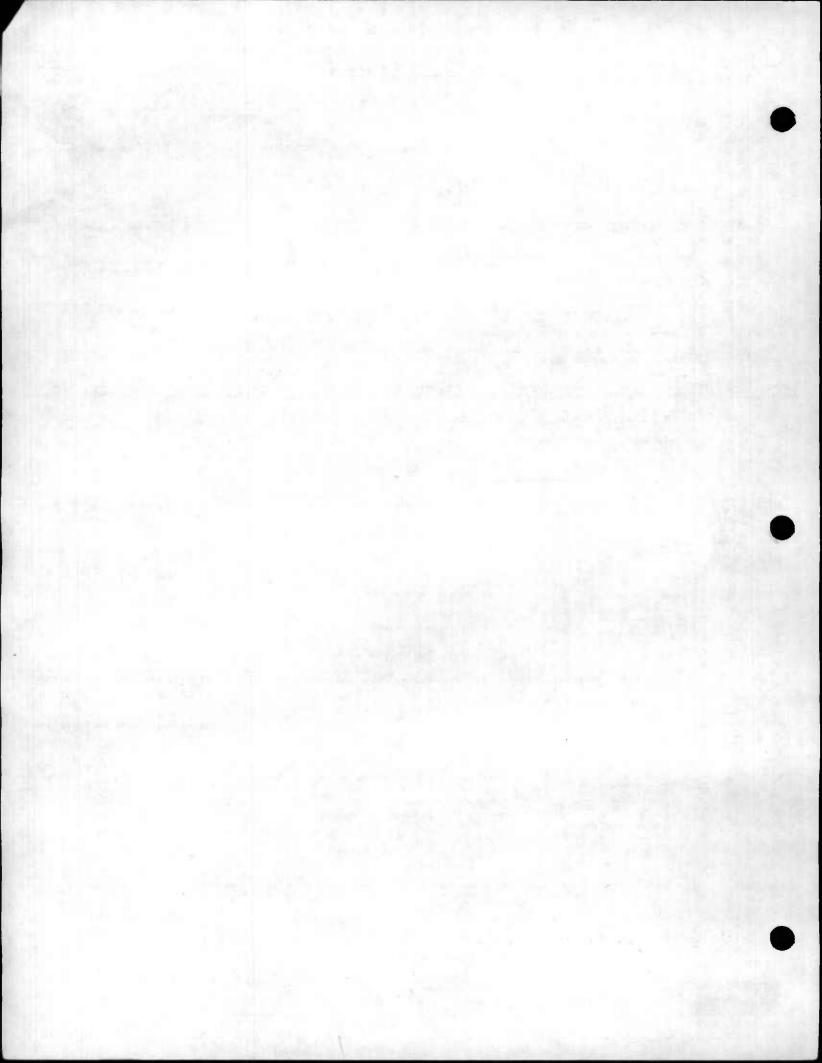
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** Benny Adelman May 16, 2:55 PM 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1⊠M 2□ F Yrs. 131-09-2492 80 Director New York Jan. 3, 1920 Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health end Mental Hygiene. Important; if Item 27 is marked other than "natural", or ferm 23a or 28a-1 ahou any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☑ Yes 2 ☐ No Director Montgomery MD Silver Spring 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2410 Homestead Dr. 20902 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 월 Yes 2 □ No If Yes, Give Yeer or Detes: WW I Reca - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Completed by WWII 3 N Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Manager Insurance 8 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Harry Adelman Unknown Unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Sherry Krause/ daughter 2410 Homestead Dr., Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete May 18, 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Lebanon Cemetery Adelphi, MD 2000 22. Name and Address of Facility 21. Signeture of Funerel Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 Approximete Intervel Between Onset end Deeth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical Sepsis sudden Examiner Due to (or as a consequence of): Physician/Medical Examiner Colitis The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last burial-trer Due to (or as a consequence of): and P.O. Box 68760. physician attending physical for use as the b Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Dementia Division of Vital Records. þ 24b. Were eutopsy findings available prior to Be Completed 24a. Wes en autopsy performed? Stroke completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Attending Physician: funeral director, 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1∑ Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 1 Yes 2 No this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturel 5 Panding investigation To the Hospital or Attendit within 24 hours after death. To the Funeral Director; Al completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) end menner steted. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D32332 May 16, 2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Syresh K. Gupta, MD, 9801 Georgia Ave., Suite 220, Silver Spring, MD 20902 31. Dete filed (Month, Dey, Year) 32. Begistrer's Signeture State

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Registrar

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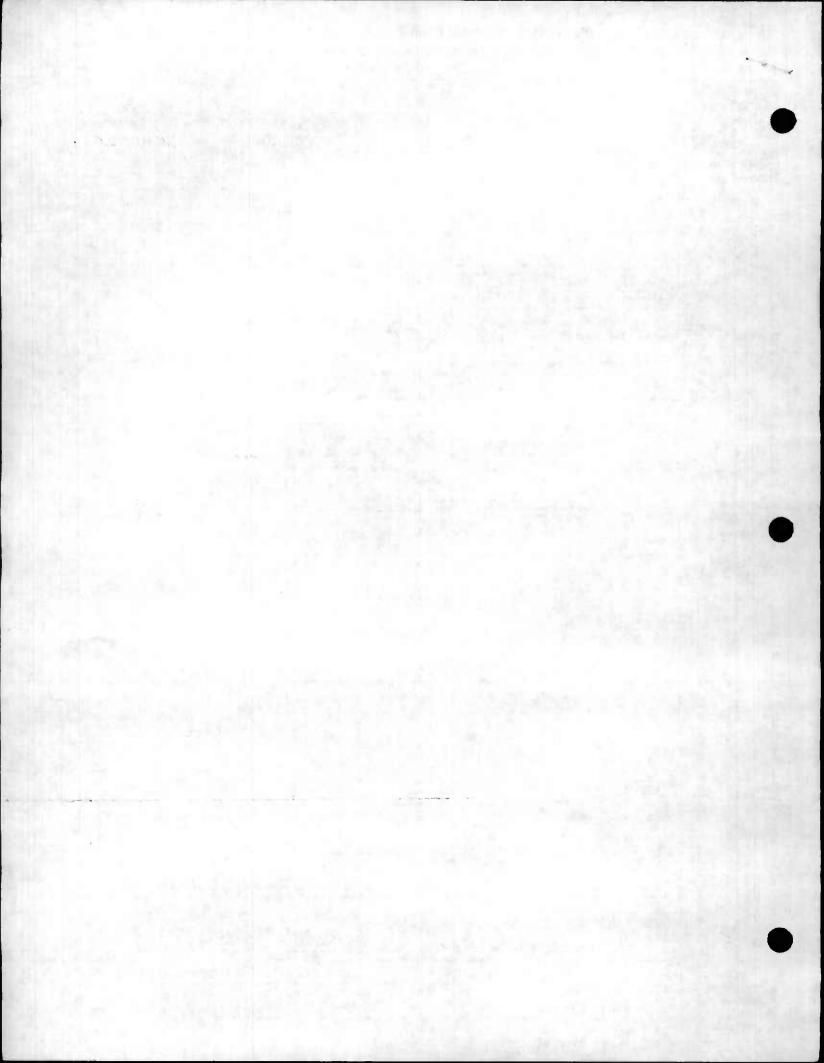


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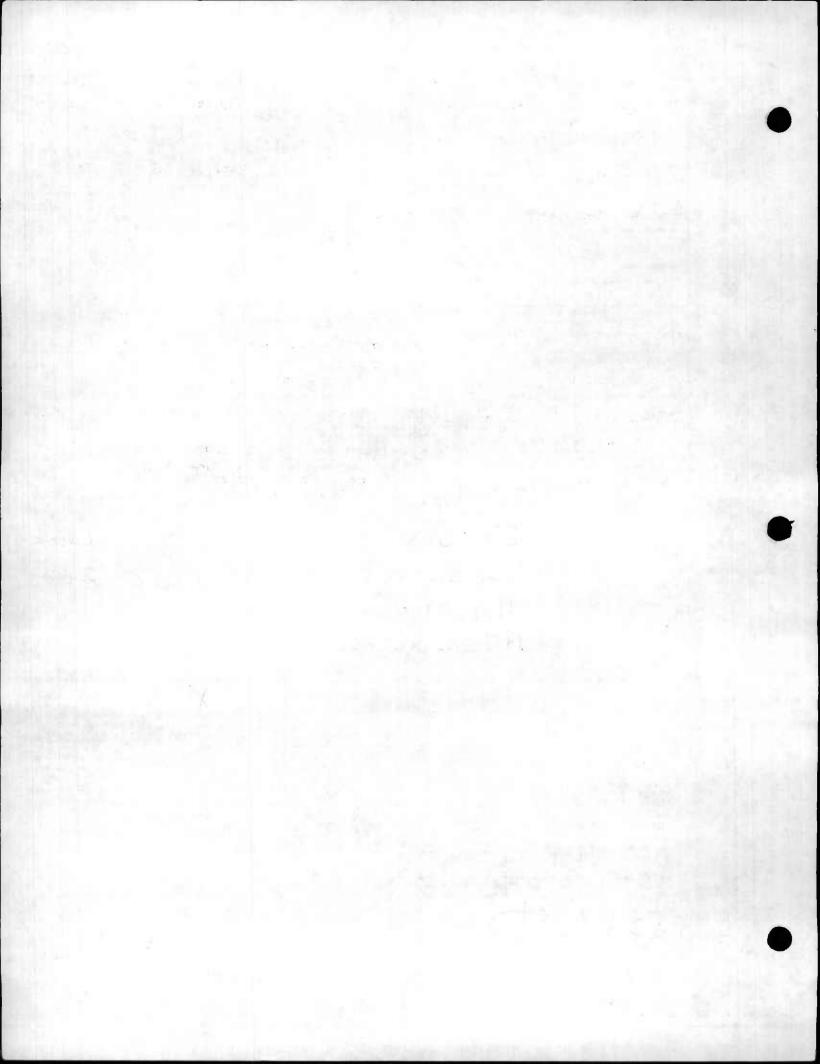
State of Maryland / Department of Health and Mental Hygiene [] []

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** May 14, Vincent Arthur Antonelli, Sr. 2000 7:15pm /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Gaithersburg Montgomery Village Care & Rehab Montgomery If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1881 M 2□ F Yrs 79 Director Mar. 9, 1921 092-16-0573 New York Usual Residence of Decedan r 28a-f show 10a State 10b Count 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 200 No Directo Gaithersburg Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or hams 23a or the Medical Examiner must be 20879 18720 Walkers Choice Road #3 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Merital Stetus Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🖾 No 1 ☐ Never Married 2 🕅 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Yeer or Dates: à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed with Department of Health and Mental hygens Important: If term 27 is marked other the eny Injury or other traumatic event, that pages. 2 Construction Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Ethel Betts 2 Tito Antonelli 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 18720 Walkers Choice Road #3, Gaithersburg, MD 20879 Beverly Jean Antonelli (Wife) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/15/00 Alexandria, Virginia Metropolitan Crematory 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, of heart fellure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediete Ceuse (Final disease or condition resulting in death) /Medical WEEK **Examiner** Due to (or as a consequence of): Physician/Medical Examiner EMENTIA YRS attending physician and for use as the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): ERTEN SION P.O. Box 68760, The lew requires that the deeth certificate be ERUSCUEROSIS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed b Records, à cate has been sig 24b. Were eutopsy findings evellable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 2 No 1 □ Yes 2 □ No 1 TYes certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 425 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠ No Certification: To 28c. Injury et Work? 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Neture 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) gand menner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D33719 May 15, 2000 Q 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) Paul T. Wielebinski M.D. 18550 Office Park Drive, Gaithersburg, MD 20886 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State spermer MAY 1 6 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Dete of Deeth 1. Decedent'a Name (First, Middle, Last) 3. Time of Death Year Month 10 2000

Physician /Medical Examiner **Funeral** Director or items 23a or 28a-f ahow union rount be notified at Director Funeral hours after 0 à

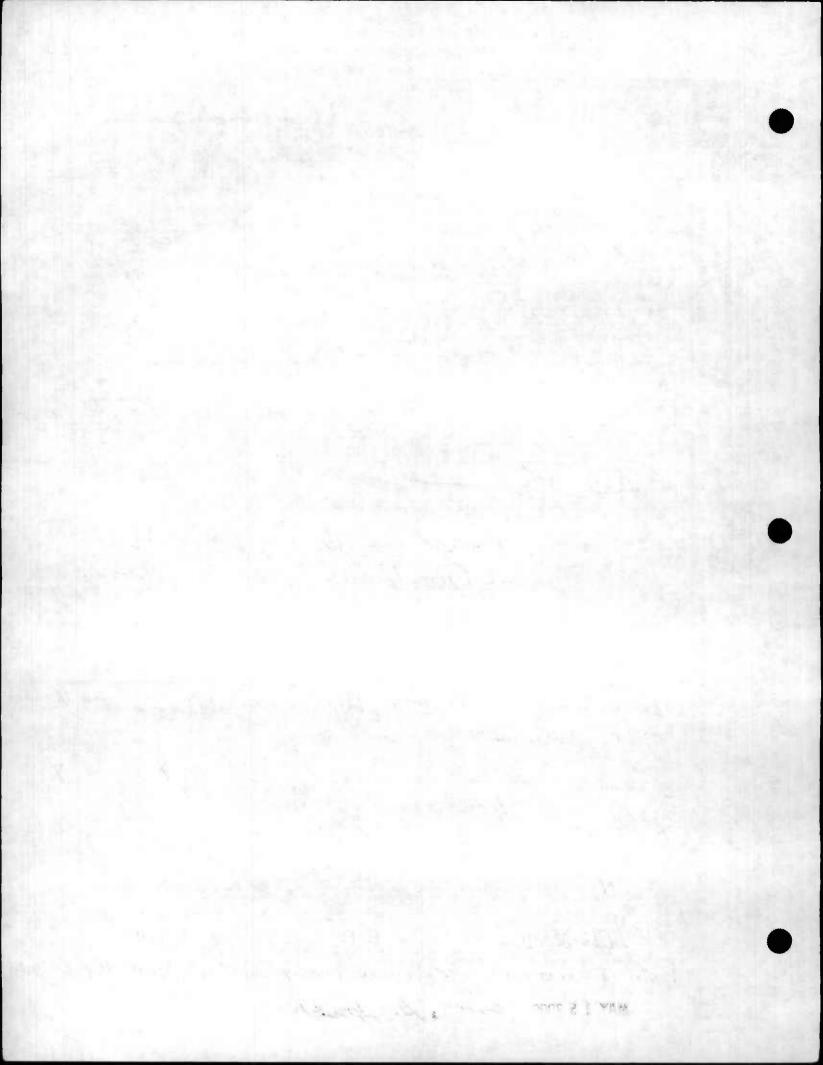
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Led other than "netue event, the Medical Peges 1 end 2 should be nent of Health and Mentel them 27 to permit. Peges 1 Department of H Important: If ite any injury or of

altimore, Maryland 21215-0020 Completed Eiementary/Secondary (0-12) College (1-4or 5+) Photographer 17. Father's Name (First, Middle, Last) Be Ralph Glenn Adams, Sr. Florence To 19a. Informant's Name/Relationship (Type, Print) Alan V. Adams/ son Date 15 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition May 2000 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Cem. nura of Fu **Physician** /Medical CONGESTIVE Immediate Cause (Final disease or condition resulting in death) Examiner Examiner OWER ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AT FIBELLATION PONATREMA Records, ρ Completed The law of Vital 25. Was case reterred to medical examiner? Be To Hospitel: 1 Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manper of Death Certification: 28b. Time of Injury 28c. Injury at Work? After 1 Natural 2 Accident Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide edicai 29a. Certifier (Check only one) 29b. Signature produttle of certifie 29c. License number 8601 VETELLUS HIGHWAY SUITE III MILLIRES ULLE MOZIOS ddress of person who completed cause of death (Item 23a) (Type, Print) OKERFEND 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State

MAY 1 5 2000

Ralph Glenn Adams, Jr 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4:40 pm 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months, Day, Year) | Sept 23, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1MM 2□ F 549-01-0772 88 1911 Nebraska Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 McKinsey Road 21146 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 11. Maritaf Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: WWII 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Motion Picture 18. Mother's Name (First, Middle, Maiden Surname) Barger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Locust Thorn Court, Millersville, MD 20c. Location - City or Town, Stete Baltimore, MD Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of death? 26. Place of Death (Check only one) Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Daty signed (Month, Day, Year) 5/11/00

Registrar DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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BARRY Meisenberry 22 South Greenest Battimore MD 21201	or or Rural Routa Number, nnar as stated. nd dua to tha causa(s)
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Little Western Sillor

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Death Year Month 11.40p EMMA MAS 2000 LOUISE AMOS 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Lorien-Riverside Nursing Center Belcamp Harford Months Days Hours Min. 8. Dete of Birth (Month, Day) If Unge. Months 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) UNKNOWN 1 M 2 F 184-22-4708 Yrs 91 1908 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1328 Cooptown Road 21050 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 11. Merifel Sfetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Vac Give Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown Domestic Worker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Walter H. Taylor Sr. Mary Smothers 19e. Informent's Neme/Reletionship (Typ 🚰 📆 nd d au ght esp Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Simpson 1241 N. Caldwell Court Beatrice E. Belcamp, Md. 21017 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 5/15 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Fairview Cemetery Forest Hill. Md. 21. Signeture of Funeral Service Ligans 22. Name end Address of Fecility E.G. Kurtz & Son Funeral Home, P.A. ackelon Jarrettsville, Maryland 23a. Pert1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each Approximete Interval Between Onset and Deeth Artery Disease Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

attending physician and for usa as the burial-transit

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Be Completed

Certification: To

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The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

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ъ Department of important: If It any injury or o

Physician/Medical Examiner

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

Due to (or es a consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1.

23b. Did tobacco use contribute to the cause of death?

Delydralus

3 Probably 4 Unknown 1 Yes 2 No

24a. Was an eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical axaminer? 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA

26. Place of Deeth (Check only one) Other: A Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No

27. Menner of Death 28e. Dete of Injury (Month, Dev Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No

1 Natural investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one)

Duran MO

29c. License number 29d. Date signed (Month, Day, Year) 1) 32609

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Kammely Musous Ho 1106

W 210 % Revolution St. Havrepelvone

State Registrar 31. Dete filed (Month, Dey, Year) MAY 1 2 2000

29b. Signeture engl title of certifier

32. Registrer's Signeture

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State Registrar

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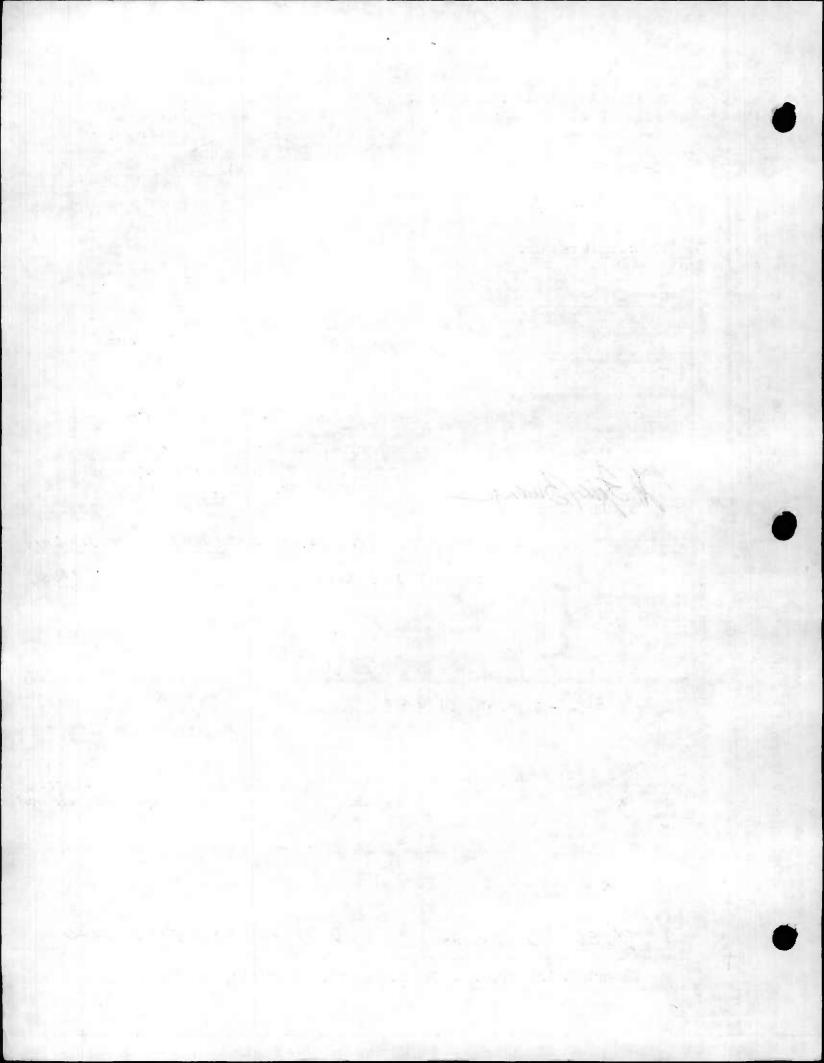
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DHANJANI MD.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2 Data of Death 3 Time of Death Year **Physician** DORIS CATHERINE TURNER ANDERSON 10:00 AM 5 12 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester 8431 Newark RD Newark H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/11/1921 5. Social Security Number If Under 1 Yaar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Days 1□ M 2 XF Yrs. 79 499-14-5872 Missouri Director Usual Rasidenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Worcester MD Berlin 1 TYAS 2 X No Director 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ъ 238 19 White Horse Dr. 21811 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 Yas **3O**(No If Yas, Giva natural, or flams 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian permit. Pages 1 and 2 should be fised within 72 hours shart. Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or fran any injury or other traumatic event, the Mantal any lines. Black, Whita, atc. 1 Never Merried 2 Married 1 Yas 2 No Specify white Specify: 3 ₩ Widowed 4 Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Own Home Homemaker 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Toney John Turner Mary Clarcy Cone 19a. Informant's Name/Ralaflonship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Donna Holdren/ Daughter 19 White Horse Dr. Berlin, MD 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata Cape Henlopen Crematory 5/12/00 Frankford, DE 4 □ Donation 5 □ Other (Specify) 22. Nama and Addrass of Facility Burbage Funeral Home 108 William St. Berlin, MD Jula estado emplications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Intervel Between Onset end Death **Physician** Immediata Causa (Final diseese or condition rasulting in death) GEREBRAL UPSCULAR ACCIDENT /Medical 24 DAYC Examiner Dua to (or as a consequence of): Physician/Medical Examiner ARYBRIU SCLERIS 5-4R5 ettending physician end for use as the burial-transit certificate be executed Sequantially list conditions, if any, laeding to immadieta causa. Entar Underlying Causa (Disaase or injury Dua to (or as a consequence of): Box 68760. that initiated events rasulting in death) Last Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ALZ HEIMERS DISENSE Records, þ 24b. Ware autopsy findings available prior to complation of cause of death? Completed 24a. Was an eutopsy performed? 1 ☐ Yas 2 ☐ No this certificate 1 Yas 2 No Division of Vital Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical etaly filled in by the funeral director, I 25. Was casa rafarred to medical axaminar? Be ASSITED 26. Placa of Death (Check only ona) Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) C Port / Hout 1 Yas 2 No Medical Certification: To 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Netural 5 Pending 1 Yas 2 No invastigation 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated. 29a. Cartifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifiar · D · 05843 - MO 5-12-2000 Man. 1140 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Robert C. LaMar, M.D. 104 N. Bay St., Snow Hill, Maryland 21863 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State MAY 1 2 2000 Registrar

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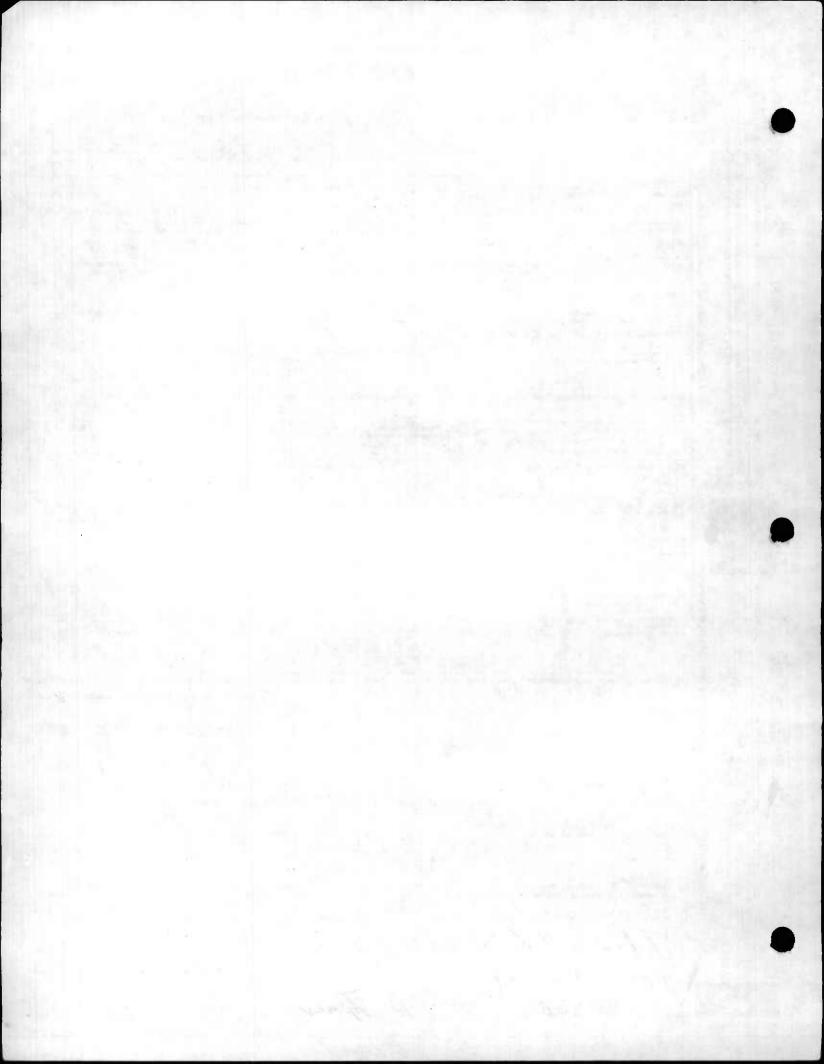


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00-2825-013 Darrell Bigham	AMEND	ITEMS:	#23	State of PART	Ma I,	ryla 27
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5	State of	Ma	ryland	1/De	partmen	t of Healt	h and	Mental	Hygiene	
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aı	A JOI Tam Dosgova D.					r Location of Deat			
or 🔠	4201 Jim Bowers R 5. Social Security Number 6. Se 213-84-7865		(In yrs. last birt	Months De		s. 8. Dete of Bi	Carr Carr Carr Carr Carr Carr Carr Carr	9. Birthpleca (State or Foreign Country) Maryland)
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	15. Decedent'a Edi (Specify only highest grad Elementary/Secondary (0-12)			Decedent's Usual Oc (Give kind of work do life. DO NOT use re Carpenter	one during most of w tired)	orking		cuction	
To Be	17. Father's Name (First, Middle, Last) (Unknown)			A Lord		eme <i>(First, Middle</i> en Griff		99)	
	19e. Informent'a Neme/Reletionship (7) Dale V. Bigham / 1		19b.	Meiling Address (Str 90 Carniv	val Drive	Taney		Stete, Zip Code) aryland 21787	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,		May 25 2000	Mount A	City or Town. State iry, Maryland				
	21. Signature of Funeral Service Licens	500 M	Skiles Fi Street	ciles Funeral Home Street Taneytown, MD 21787 or respiratory errest, Approximate					
Examiner	Immediate Cause (Finet disease or condition resulting in death) Sequentially list conditions.	e	ue to (or es a c	INTOXICAT consequence of):	ION			Onset and Death	
Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	ue to (or as a co	onsequence of):					
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Completed by							s an autopsy ormed?	24b. Wara autopsy findings available prior to completion of cause of death?	
S						Jo	¥es 2□No	1 Ves 2□ No	
ED3	25. Wes case referred to medical examiner?	Hospitei:			Other:	eeth (Check only			
itlon: To	27. Manner of Death 1 Neturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Day) FOUND:	(ear) 28b. T	ime of A 28c. f	njury et Work? 1 Yes 2 No	28d. Describe	how injury occur	er (Specify) Scene red STED DRUG	
Certification:	3 Suicide 6 Could not be determined	5-19-00 28e. Pleca of Injury building, etc. (RE.	9:4	m, atreet, factory, off			(Street end Numb wn, Stete) 420 VILLE, M	of or Bural Route Number. 1 _ JIM _ BOWERS . H	D
	29a. Certifier (Check only one) 1□ Certifying Phy All Certifying Ph	sician: To the best of riner: On the basis of end menner atete	caminetion and	deeth occurred at the	e time, date and plan ny opinion, deeth oc	e, end due to the	cause(s) and me		
	29b. Signeture end title of certifier	1.16.2	ans	0.	ense number C.M.E.		29d. Data signed May 21,	d (Month, Dey, Year)	
-	30. Name and address of person who co			The state of the s					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2 Date of Deeth 3. Time of Deeth Month **Physician** /Medical 4a. Fecility Nema (If not institution, give 4b. City, Town, or Location of Daeth, 4c. County of Deeth **Examiner** CITA PRINCE (9000) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 8. Dete of Birth (Month, Day, Yeer) Days 78 291-16-2887 Director Usual Residence of Decedent tha Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Maryland Prince George's Director Mitchellville 1 ☐ Yes 2 TrNo 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? ò 'natural', or itams 23a 10450 Lottsford Rd. #205 20721 Funeral United States 11. Maritei Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. filed within 72 hours aftar 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National Council of Hygiane. Elementery/Sacondery (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed wit Department of Haeith and Mantal Phygiene Important: If item 27 is marked other tha any injury or other traumetic event, in a once. Excutive Secretary Farmers Co-Op 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Martin Vessey Goldie Suppanos 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Roy Battles / Husband 10450 Lottsford Rd #205, Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2000 Beltsville, MD Funarai Servica Licenses 22. Name end Address of Fecility Rapp Funeral and Cremation Services 933 Gist Ave Silver Spring, MD 20910 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Batween Onset and Deeth **Physician** /Medical Immedieta Ceuse (Final Failure to Thrive 2 months disease or condition resulting in death) Examiner Due to (or es e consequence of): Dementia of Alzheimer's The law requires that the death certificate be executed Exami Sequantielly list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disaase or Injury that Initiated events resulting in deeth) Last been signed by the ettending physician and should be deteched for use as the burial-tran Due to (or es e consequance of): P.O. Box 68760, Physician/Medical Due to (or es a consequança of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee ŽŒNo 3 Probably 4 Unknown Records. þ 24b. Wera eutopsy findings available prior to complation of ceuse of death? Completed 24e. Wes en autopsy has page 2 cartificate 1 Yes 2XXNo 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: director, Be 25. Wes cese referred to medical exeminar? 26. Plece of Deeth (Check only ona) Hospitel: Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funaral 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred Aftar 1 Netural 5 Pending Investigation Injury efter daath. Director: Af 1 Yes 2 No 2 Accidant the 6 Could not be determined 3 Suicide 28a. Pleca of Injury - At home, ferm, street, fectory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours e Funeral C 1Exertifying Physicien: To the best of my knowledga, daath occurred et tha tima, data end pleca, and dua to tha ceusa(s) and menner es steted.

2 Medical Examiner: On the best of exeminetion end/or invastigation, in my opinion, deeth occurred et the tima, date end plece, end dua to the cause(s) end menner steted. 29a, Cartifian Medical complately (Check only one) To the Vithin 2 29b. Signature and title of a 29c. Licanse number 29d. Data signed (Month, Dey, Yeer) 30. Neme and eddress of person who completed cause of death (item 23e) (Type, Print) William F. DuBoyce, M.D. 4000 Mitchellville Rd. Suite B216 Bowie, MD 20716

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State

Registrar

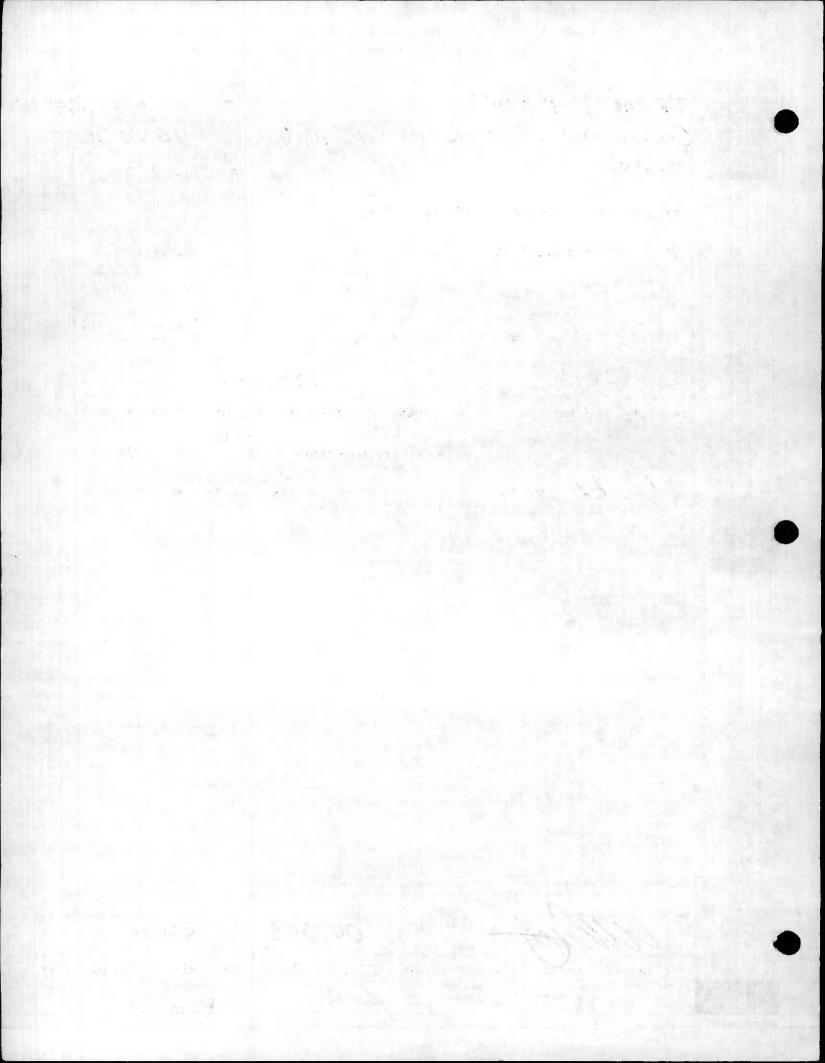
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32. Begistrar's Signetura

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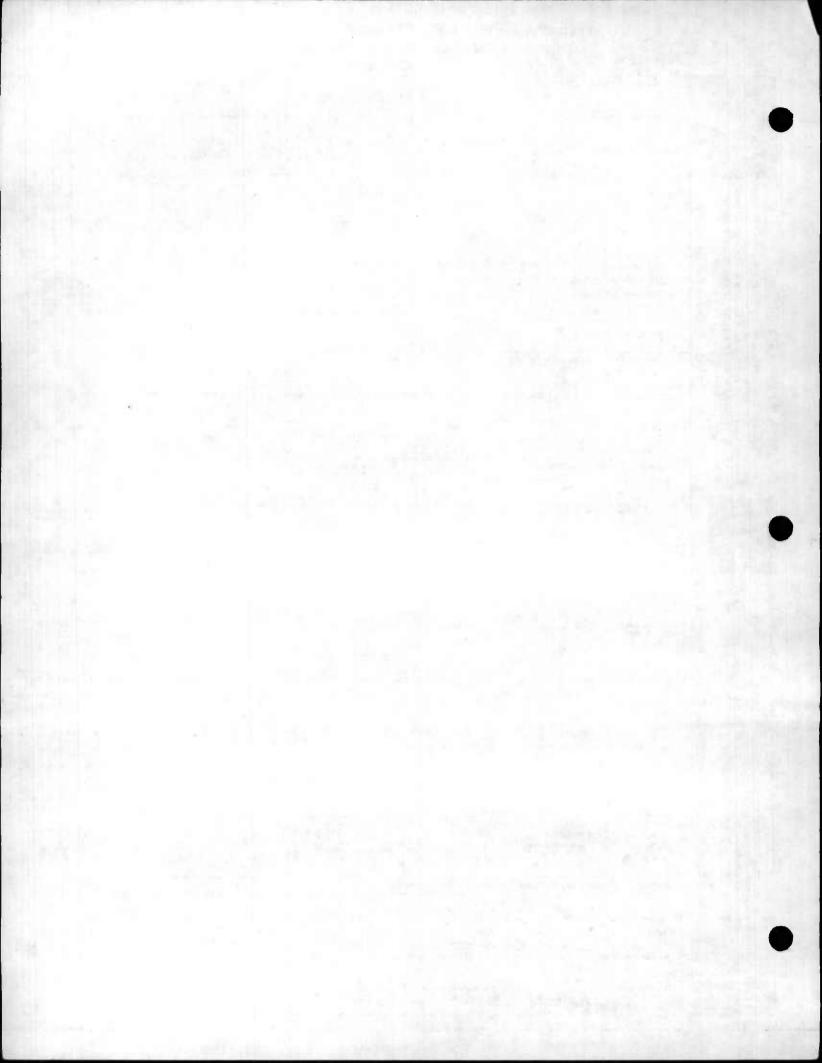
Piease Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7235 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month 9, Robert S. Berns May 2000 11:15 PM /Medical 4a Facility Name (II not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY Hours Min. 8. Date of Birth (Month, Dey, Year)
June 2, 190 If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1⊠ M 2□ F 90 Yrs. Director 154-10-2213 1909 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1E Yes 2 □ No Directo MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or itsms 23a 18853 Bent Willow Circle, Apt. 718 20874 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: ⋛ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flied within Elementary/Secondary (0-12) College (1-4or 5+) 5+ Law Attorney permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Nem 27 is marked other
any Injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Isidor Bernstein Pauline Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Peter V. Berns/ Son 6305 Clearspring Rd., Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1₺ Buriel 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens 2000 4 ☐ Donation 5 ☐ Other (Specify) Olney, MD 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc.
1170 Rockville Pike, Rockville, MD 20852 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Pneumonia 5 days Examiner Due to (or es a consequence of): Physician/Medical Examiner Cardiomyopathy months The law requires that the death certificete be executed attending physician and for use as the buriel-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es a consequence of): Chronic Renal Failure months Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of) Dehydration days P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yss 2 No 3 Probably 4∑ Unknown Records. þ cate has been sig.; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, g Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1₺ Inpatient 2☐ ER/Outpatient 3☐ DOA Division of 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury st Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in edicai 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Dete signed (Month, Day, Year) 0052322 May 10, 2000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mikhail Gendel, MD 14820 Physicians Lane, #243, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrer's Signatura State

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Registrar

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month May Year LOOM **Physician** VelyN 2000 3:40 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examine Montgomery Silver Spring 9613 East Light Dr If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Apr 23, 1922 Birthpiece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Hours Months Devs 1 M 2 N F Yrs 78 Washington, Director 577-22-6652 Usual Residence of Decedent death with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ahow r than "natural", or items 23a or 28a-f ahov The Madical Examiner must be notified at 1 Yes 2 No Directo Silver Spring Maryland Montgomery 10f. Zin Code 10g. Citizen of Whet Country? 10e Street and Number 20903 IISA 9613 East Light Dr Funeral Race - American Indien, Bieck, White, etc. 12. Was Decedent Ever In U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Medital Status pemil. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. In mortant: if frem 27 is marked other than "natural", or frem any injury or other traumatic event, the Magical Federal 1 ☐ Yes 27 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify. by 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Margaretha Troeger Gottfried Fankhauser 19b. Meiling Address (Straet end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 15221 Centergate Dr, Silver Spring, MD 20905 Joanne Anderson/Daughter 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece, 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State May 19 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Crematory Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Pert1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. Vist only one ceuse on eech line. Approximete Intervei Between Onset end Deeth **Physician** e ENd-Stage Chronic Obstructive
Due to (or es e consequence of): Pulmonary disease /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner physician and s the buriel-transit law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) 80 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the signed by the 1 Yee 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings aveilebte prior to completion of cause of death? should 24e. Wes en autopsy Completed s certificete has b 1 ☐ Yes 2 ☐ No 1 □ Yes 2 □ No or Attending Physician: efter death. director. Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Certification: After 1 DNaturet 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident within 24 hours efter death To the Funeral Director: / completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner as steted.

Legislatic Course of the time, dete and piece, end due to the ceuse(s) end menner stated. 29e. Certifier edicai (Check only one) the

29c. License number

D28267

11402 Allview DR, Beltsville, Md

29d. Date signed (Month, Dey, Year)

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Registrar

2

29b. Signature and title of certifie

31. Date filed (Month, Dey, Year)

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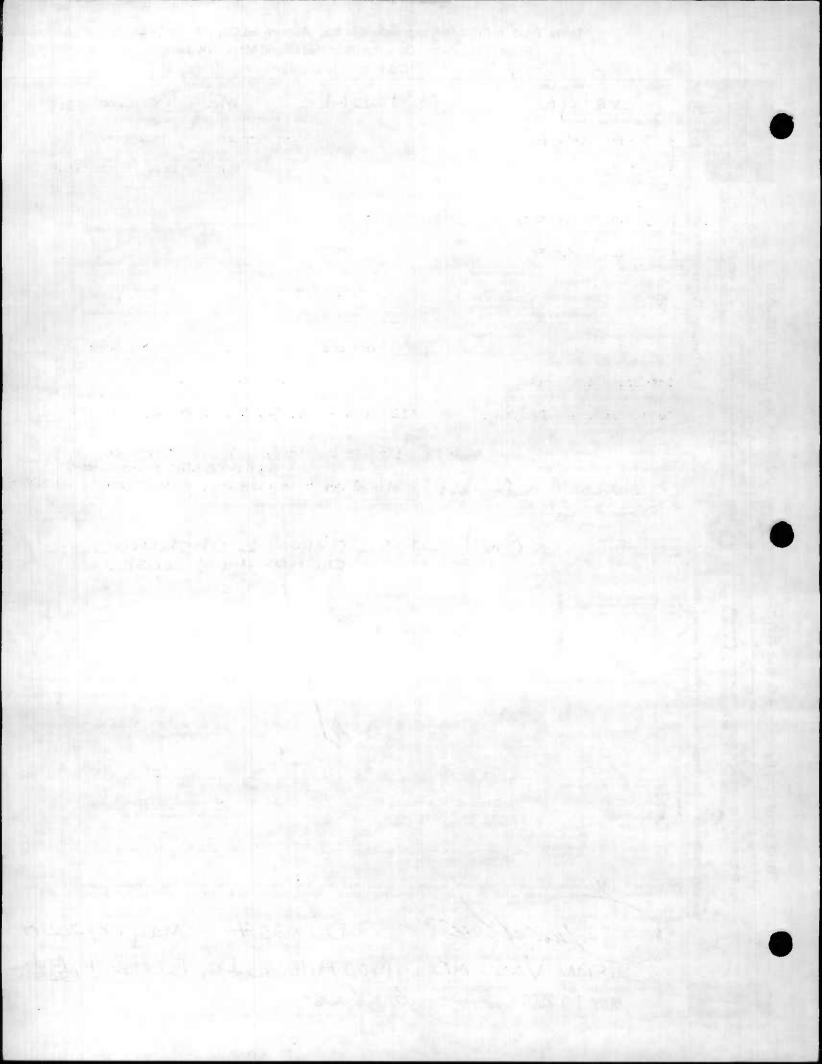
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and address of person who completed cause of deeth (Item 23e) (Type, Print)

2000

OSS, MD

32. Registrer's Signature

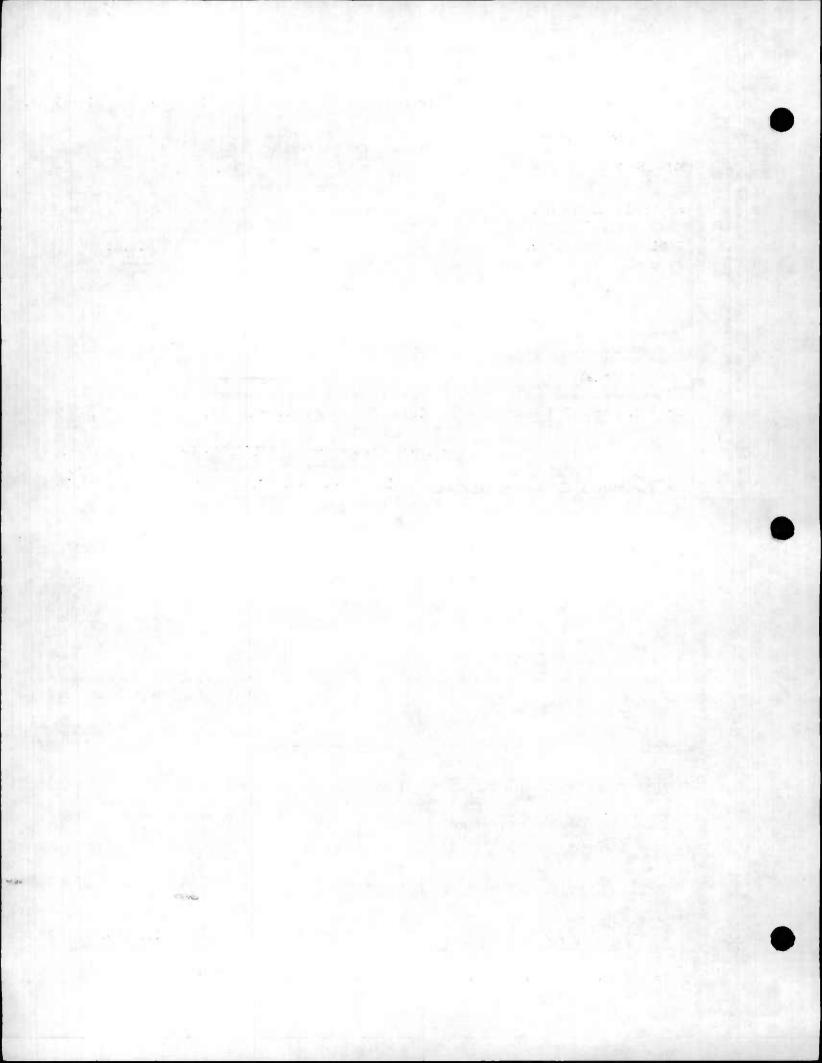


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State of Maryland / Department of Health and Mental Hygiene 0

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ē	building, atc. (Specify) City or Town, Stata)													
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17. Father's Name (First, Models, Machen Summen) 18. Mother's Name (First, Models, Machen Summen) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, 2th Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, 2th Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, 2th Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, 2th Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, 2th Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, 2th Code, 19. Mailing Address or Steley		-	15. Decedent's Edu			cation	cation 16e. Decedent's Usuel			suel Occup	pation	A adad	ia a	16b. Kind of B					
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State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month Year **Physician** rowN 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arunde1 If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Months 1 M 202F Yrs. Director 217-22-8065 Maryland Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 Xes 2 □ No Directo Maryland Anne Arundel Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Academy St 21401 II.S permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if flam 27 is marked other than any Injury or other traumant. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Meritel Stetus Bleck, Whita, etc. 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 Never Merried 2 Married 1 Yes No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 2 Cincinatta Hook Agnes Beall 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 2121 Deta | 20c. Location - City or Town, Stete Joyce Dale Sawyer/daughter 702 Stoneleigh Rd MD 21212 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition Deta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 5/22/00 Annapolis, MD 21. Signature of Funeral Service Ligens 22. Neme end Address of Fecility John M. Taylor F.H. 23a. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast.

Annapolis, Approximete shock, or heert tellure. List only one cause on each line. Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disaese or condition resulting in death) rumonia Examiner Due to (or es e consequenca ot): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and burial-tran Due to (or es e consequence ot): Box 68760, attending physician for use as the burie Physician/Medical Due to (or es e consequenca of): Pert It. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 ☐ Unknown signed be det þ 24b. Were autopsy tindings available prior to 24e. Wes en eutopsy performed? Completed peeu completion of causa of death? has r this certificate h 2 0 No 2/2 No 1 Yes of Vital Physician: 25. Wes case reterred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? al or Attending P s after death.
If Director: After bed in by the funer After Neturel 5 Pending investigation Division 1 Yes 2 No 2 Accident 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide Pleca of Injury - At home, term, street, factory, offica building, etc. (Specify) 4 Homicide filled in t To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian edicai (Check only one 29c. License number 29d. Dete signed (Month, Pey, Year) 29b. Signature and title of certifier 000 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 40 Tree 6 32. Ragistrar's Signature 31. Date filed (Month, Dey, Year) State MAY 2 2 2000 Registrar

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State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Year **Physician** BREWER DERRY 3:12 AM 2000 17 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY MERCY MEDICAL CENTEIL BALTIMORE If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2□ F Yrs. Director 68 250-40-5391 OCT. 10 1931 S. CAROLINA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Mexical Examiner must be notified at 1X Yes 2 □ No Director MARYLAND NONE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number STREET 1339 HOMESTEAD 21218 Funeral USA death 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Raca - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after Department of Health end Mentel Hyglene. Important: If Item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Health Evantme. 1 Never Married An Married Specify: BLACK Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th 0 TRUCK DRIVER BALTIMORE CITY 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be HERBERT BREWER LUCILLE VAUGHN 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stete, Zip Code) ELIZABETH BREWER (WIFE) 1339 HOMESTEAD ST. BALTIM ORE, MD. 21218 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/22/00 OWENSVILLE, MD. CHEWS CHURCH CEME. 21. Signatura of Funarai Sarvice Licensaa MOO483 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. Larry D. Keese 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Daath **Physician** Immediate Cause (Final disaasa or condition resulting in death) /Medical a METABOLIC Examiner Examiner INSUFACIENCY CHRONIC RENAL physician end s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead of the cause). Due to (or as a consequence of): P.O. Box 68760. DIABETES MELLITU Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) as ettending | signed by the eld be detached f 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings available prior to completion of cause of death? been sign Completed 24a. Was an autopsy performed? Yes 1 ☐ Yes 20 No 2 No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: DOA 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 2 1 Yes 250No this funeral 28a. Date of injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: After 5 Pending investigation 1 Naturai death. 1 Yes 2 No 2 Accident or Attendate after deat Director: 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide e Hospital To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P13402 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEPART MENT OF MEDICINE, MERCY HOS PITAL KATHERING NOE, MD 301 ST. PAVE PLACE, BALTIMORE MD

Registrar

State

31. Date filed (Month, Day, Year)

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32 Registrar's Signatura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND# 17, 18 5/18/00 cmh AACO Health Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death L. May Month **Physician** Renee Brokx 13, 10:30 am 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House of Friendship Hanover Anne Arundel 5. Social Sacurity Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Feb 2, 1908 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 F 161-20-0510 92 Yrs. Director France Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park 1 Yes 2 No Director 288-1 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 343 Lynwood Drive USA 21146 238 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, etc. 1 ☐ Nevar Married 2 ☐ Married à 21215-0020 1 Yes 2 No Specify: White Specify: 3 Divorced 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) filed within Elementary/Secondary (0-12) College (1-4or 5+) Mailroom Manager Banking Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Meunier and 2 should be saith and Mental Mathilde F. Meunier Emil Hartman Emile Hartmann Mathilde F. Mounid permit, Pages 1 and 2 st. Department of Health and Important: If Item 27 is ma any injury or other traum 2005. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 343 Lynwood Drive, Severna Park, MD John P.E. Brokx/ son 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, State cometery, crematory or other place)
Our Lady of the Fields 1 XBurial 2 Cremation 3 Removat from Stata May 17 Millersville, MD 4 ☐ Donation 5 ☐ Othar (Specify) Church Cemetery
22. Nama and Address of Facility 2000 21. Signature of Funeral Service Lice Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximata Interval Between Onset and Death **Physician** Immediata Cause (Final disaasa or condition rasulting In daath) /Medical dente myounded Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit Sequentially list conditions, if any, laading to Immadiata causa. Entar Undartying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Dua to (or as a consequence of) P.O. Part II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic deplession Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred Division 5 Pending invastigation Natural 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Dr. James J. Benjamin, 479 Jumpers Hole Road, Suite 304, Severna Park, MD 21146 31. Date filed (Month, Day, Year)
MAY 1 8 2000 32. Registrar's Signatura

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

THE S I YAY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #1 PER MD G784 6/28/00 AH Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Jeanne Brantley JEANNETTE W. BRANTLEY April 14,2000 04:30pm /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facitity Neme (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Hours 10 M 20 F Months Days Yrs. 416-60-4320 59 Director May 19, 1940 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Westerl Examiner must be notified at 1 Yes 2 No Director Montgomery Silver Spring 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 710 Roeder Road 20910 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 72 hours after 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "n any Injury or other treumetic event. Etementery/Secondary (0-12) College (1-4or 5+) 12 4 accounting finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) 36 Walter F. Pitts 0 Inez J. Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Penny Johnson/daughter in law 19274 Wheatfield Terr Gaithersburg, MD 20879 altimore, 20b. Place of Disposition (Neme of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signature of Funerat Service Licensee Ronald S. Wade, 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street nacon Jack Baltimore, MD 21201 Approximate Interval Between Onset end Death 23a Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart teiture. List only one cause on each line. **Physician** /Medical Immediate Cause (Finet disease or condition resulting in death) Cardiorespiratory Arrest Examiner Due to (or as a consequence of): Examiner Increased intracranial pressure physician and s the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): certificate be exec Ruptured Brain Aneurysm Box 68760 Physician/Medical Due to (or as a consequence of): 98 Stroke/Massive Hemorrhage USB ó 23b. Did tobacco use contribute to the cause of death? P.O. be detached Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. the signed by 1 Yes 21 No 3 Probably 4 Unknown of Vital Records. ģ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? director Be 26. Place of Death (Check only one) Hospitet: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Netural 28a. Date of Injury (Month, Dey Year) uneral Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation death. 1 TYes 2 TNo Director: A d in by the f 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by or A 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifie 29c. License numbar

State Registrar

JUN 0 1 2000 DHMH 16 Rev 6/95

Bernard Stopak MD

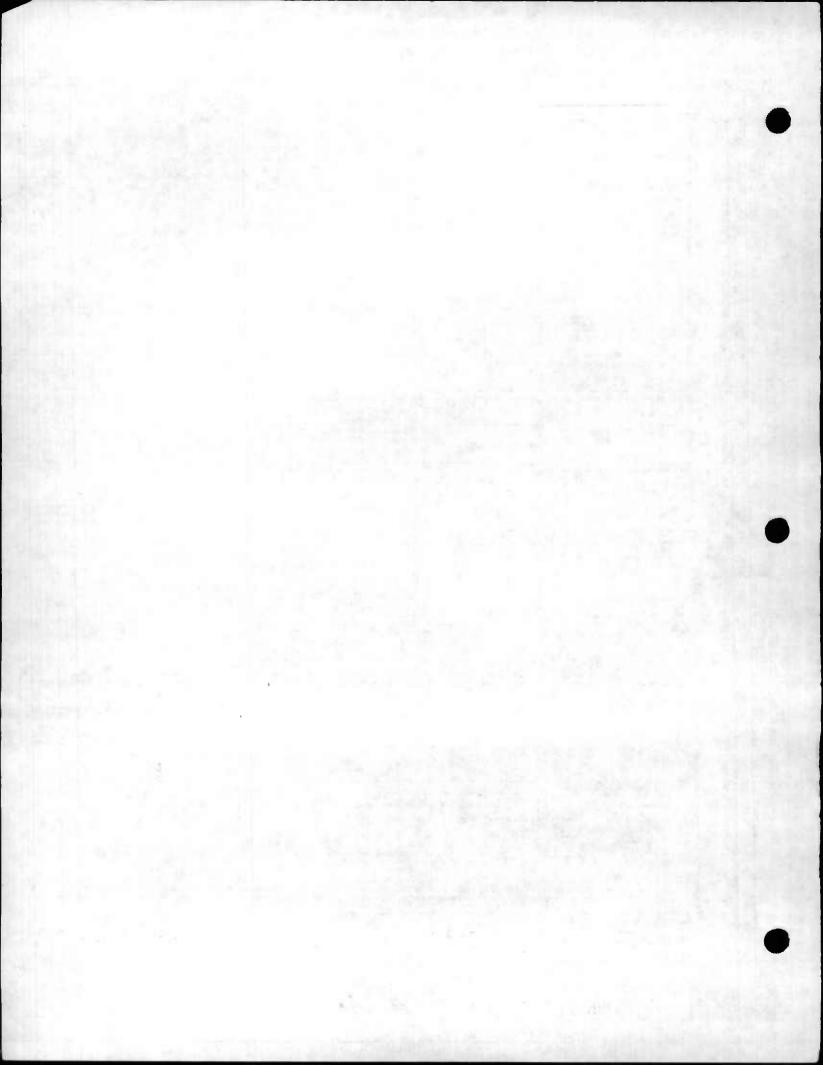
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32. Registrar's Signature

5454 Wisconsin Ave Chevy Chase Md 20815

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

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/ /Medi		Anna (NMN)		mgartne:	r			May	May 8, 2000			10:00 PM	
Exami	ner	4a. Facility Nama (If not Institution, giv 299 Wakely Terra		m <i>ber)</i>			4b. City, Tov Bel	wn, or Location Air	of Death	4c. County			
Funeral		5. Social Security Number 6. S		7. Aga (In yrs.	last birthday)		r If Under		ata of Birth Ionth, Day,			piaca (Stata or Foreign	
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mit. Pa sartmen oortant: injury		4 ☐ Donation 5 ☐ Other (Spacify 21. Signature of Funeral Service Licer		Mt		United 2. Nama and Addr			L/00 I	Bel Air	, MD		
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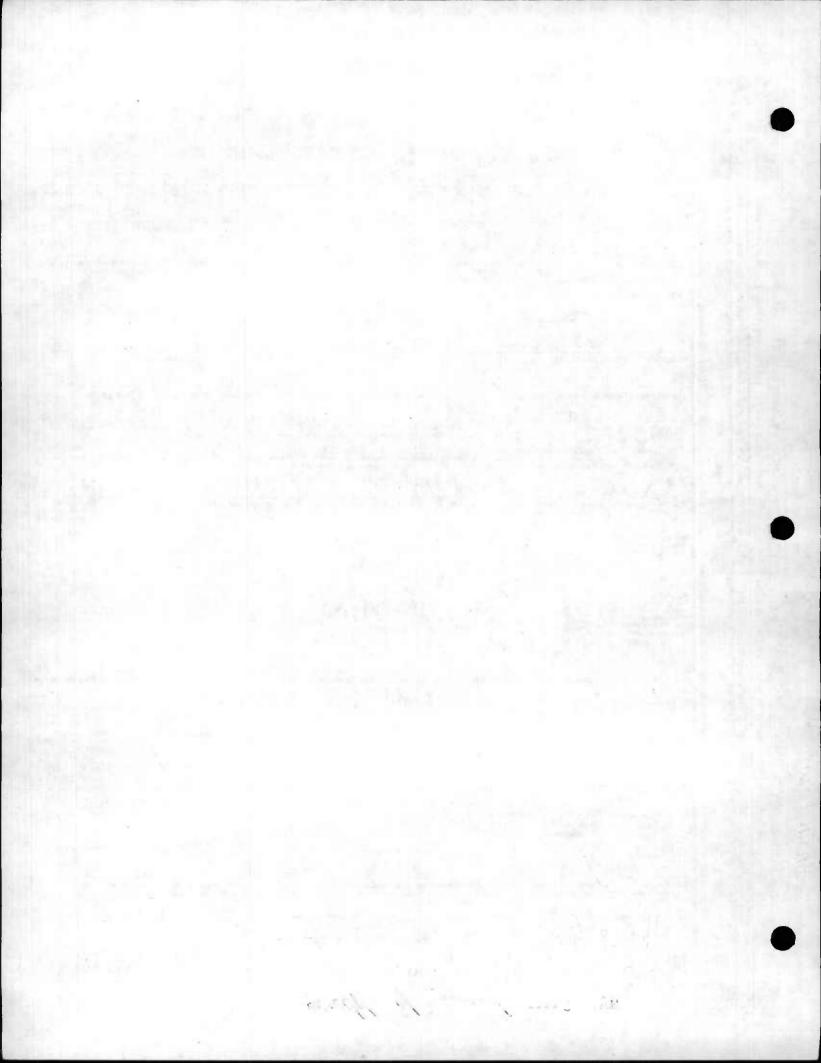
Maria House I Yo

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 244 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Louis Edward Brown, Jr. May 2000 5 7:56 am /Medical 4a Facility Neme (Il not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace
ar If Under 24 Hrs. 8. Dete of 8. (Month, Month, M Harford If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1₩ M 2□ F Yes Director 213-18-3532 78 05/02/1922 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 1940 Nobles Mills Road 21034 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, While, etc. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: White à 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemeniery/Secondary (0-12) College (1-4or 5+) 4 years Chief Warrant Officer U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Louis Edward Brown, Sr. Blanche T. Morrow 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard H. Brown- Executor 1 Sycamore Rd., Scituate, Mass. 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ferris and Co. Inc. 5/9/00 West Chester, PA 21. Signature of Funeral Service Licanses 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, WD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury for use as the burial-tran P.O. Box 68760. Physician/Medical that initieted events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records. Be Completed by should be 24b. Were autopsy tindings aveilable prior to 24e. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 2010 this certificate or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Ye 10 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Pending 1 Yes 2 No death. Investigation 2 Accident To the Hospital or Attend within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide Medicai 29a. Certifier 15 Contifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. signed (Month, Day, Year) 29b. Sighature and title of certifie 29c. License numbe qause of death (Item 23a) (Type, Print) MION nth, Day, Year Registrar's Signature State 8 2000 MAY Registrar DHMH 16 Rev 6/95

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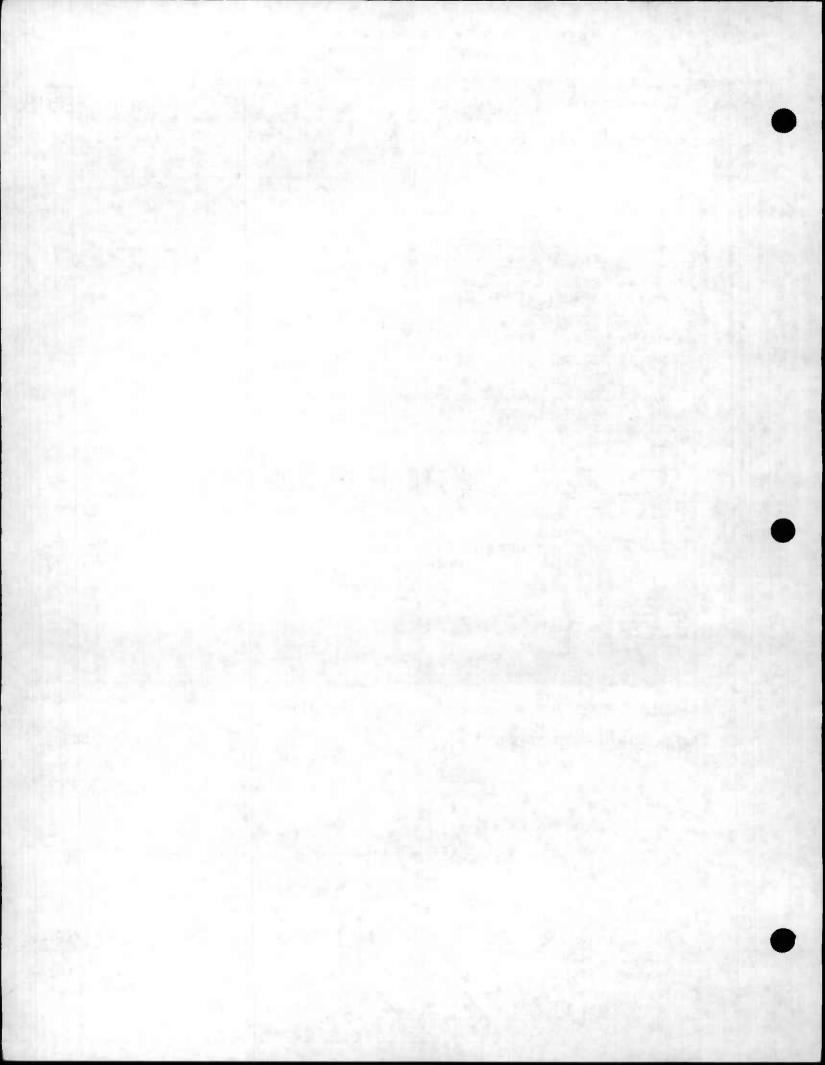
State of Maryland / Department of Health and Mental Hygiene 7245 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2:54 PM ERNEST Ruck 2000 16 /Medical 48 Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMAIA 14 OWARD (OUNTY HOSPITAL JANERAL) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** ₩ M 2□F 213 20 0705 76 Director Apr 16, 1924 Maryland Usual Residence of Decedent with the Meryland 10a State 10h County 10c. City, Town or Location ahow 10d, Inside City Limita itam 27 is marked other than "natural", or hams 23a or 28a-f show other traumetic avant, the Madrial Examiner must be notified as 1 ☐ Yea 2 No Director MD Howard Ellicott City 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 8409 West Grove Road 21043 United States death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainments. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Vea 2 No
H Yes, Give
Year or Dates 1943-45 1 Never Married 2 Married 1 Yea 2 No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Theodore Ridgely Buck Dora Elizabeth Lober 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Addresa (Street end Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Buck/Wife 8409 West Grove Road Ellicott City, MD 21043 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Cemetery 5-19-2000 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee mo 1044 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CARCINOMA OF LUNG DIFFERENTIATED MONTH disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Medical Certification: To Be Completed by Physician/Medical the Due to (or as a consequence of) 80 USB P.O. Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No CORONARY ARTERY DUFASE DIABETES MELLITUS of Vital Records, 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? FIBELLIATION, HYPERTENSION 1 Yea 2 No 1 ☐ Yes 2 ☐ No after death.

Director: After this certified in by the funerel director, Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 PNaturel Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and ville of certifier 29c. License number 1) 38296 MAY 16,2000 Mms, mo 30. Name and sources of person who completed cause of death (Item 23a) (Type, Print) , MD 9501 OLD ANNA POLISROAD, ELLICOTT CITY, MD 21042 JOSETH F. GIBBONS 31. Date filed (Month, Day, Year) 32. Registrac's Signature State

DHMH 16 Rev 6/95

Registrar

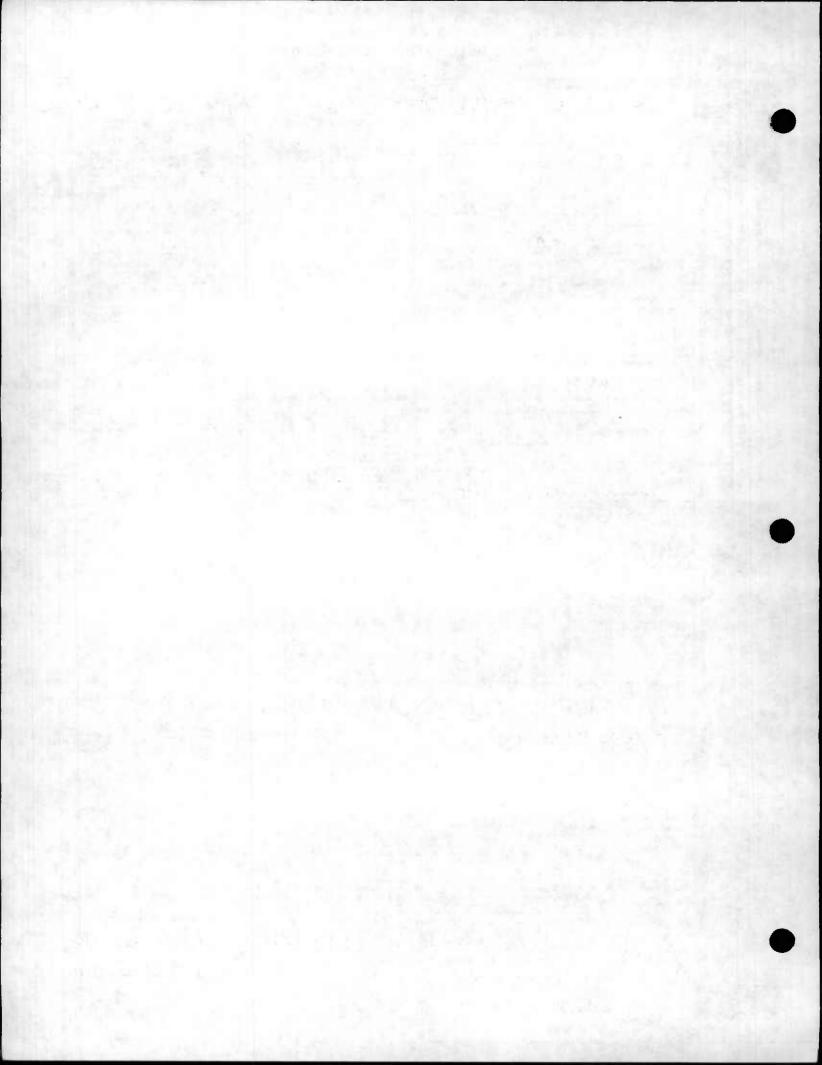
MAY 1 8 2000 >



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** earmar 0005 2000 renne /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 24 Hrs. Hours | Min. If Linder 1 Year 9. Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Deys 1□ M 2 F YES 215 07 4596 Director 81 Oct 6, 1918 Maryland Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tems 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11315 Little Patuxent Parkway #218 21044 United States Funeral 12. Wes Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is merked offer than "natural", or the eny injury or other traumatic event. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Maryland 21215-0020 1 Yes 2X No Specify. py Specify 3 ☐ Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Charles Minnick Harriet Cooper 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Melvin R. Bearman/Husband 11315 Little Patuxent Parkway #218 Columbia MD 21044 altimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 5-16-2000 Catonsville, MD 22. Name end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 21. Signeture of Funerel Service Licenses MO1044 4112 Old Columbia Pike Ellicott City, MD 21043 0 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner pendicity 5 and Obcess Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last **burial-tran** and physician Box 68760 by Physician/Medical the Due to (or es e consequence of) 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. ata has been signed by page 2 should be detach 1 □ Yss 2 No 3 Probably 4 Unknown Records, 24a. Wes en eutopsy performed? Were autopsy findings eveileble prior to Completed completion of cause of death? certificate has No 1 Yes 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? After Division Attending 5 Pending Investigation 1 Netural 1 Tyes 2 No death. al or Attendil s after death. I Director: A od in by the fu 2 Accident 6 Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifie 29c. License number ed cause of deeth (Item 23a) (Type, Print) COLUMBIA MA 21045 edman SNOL 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State MAY 1 8 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 DALE GRADY BRUCE May 2000 12:00pm 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. Clty, Town, or Location of Death 2830 Southview Road Ellicott City Howard If Undar 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dey, Year) July 28, 1959 Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Months Days MAN OF F Yrs 215 74 0956 40 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City I Imits 1 ☐ Yes 2 ANo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? 2830 Southview Drive 21042 United States 11. Marital Status 12. Was Decadent Ever In U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Managed Care Advisor Healthcare 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Wallace G. Bruce Janet Elfrey 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2830 Southview Road Ellicott City, MD 21042 Janet Bruce/Mother 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 DXBurial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Crest Lawn Cemetery 5-16-2000 Marriottsville, MD 21. Signature of Funeral Service Licansee MCIC44 22. Name and Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final minutes diseese or condition resulting in death) Verression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): that initiated events resulting in death) Last Dua to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probabty 4 Unknown 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 113 Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Other (Specify)

Physician /Medical Examiner

Examiner

Completed

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10

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Physician

/Medical

Examiner

Director

Funeral

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7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than *r any Injury or other traumatic event, if a Med police.

72 hours efter

Baltimore, Maryland 21215-0020

Box 68760

Records, P.O.

of Vital

Division Hospital or Attending

law requires that the death certificete be

The

burial-tra inding physician use es the burial Physiclan/Medical for u been signed be should be deta ð page 2 has certificate this Certification: After 24 hours after death.

Funeral Director: Aft letely filled in by the fu

To the Hosp within 24 hou To the Fune completely fi U

State

Registrar

PATIZYCE 31. Date filed (Month, Dey, Year)

29b. Gignature and the of certifier

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrer's Signature

may 12,2000 ~ 12 P

28b. Time of

Deput

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

basement

29c. License number

1 Yes 2 No

28c. tnjury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and mannar stated. 29d. Date signed (Month, Dav. Year)

281. Location (Street and Number or Rural Route Number, City or Town, State) 2830 South vice RD Ellizoth City

hanging

May 13, 2000

28d. Describe how injury occurred

selfinflicted

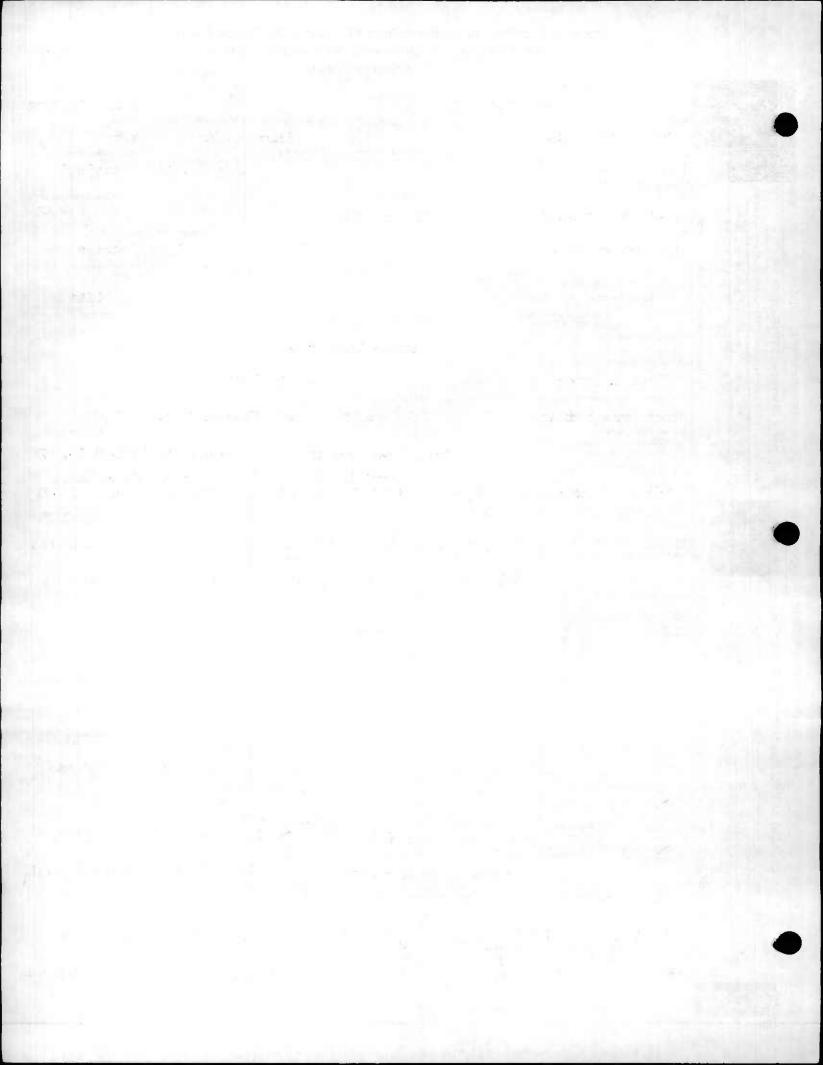
A. TOTE, MD 4565 Hemlock Cone Way Ellichtag

MAY 1 5 2000

28a. Date of Injury (Month, Day Year)

homein

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Deeth Month Day **Physician** 104 Ce 16:01 05 112000 /Medical lity Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Mill if Under 24 Hrs 000 Morcester AN Social Sacurity Number If Under 1 Yaar Birthplece (State or Foreign Country) 6. Sax 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours. 1□M 2 F -32-1985 Director 220 Usual Rasidance of Decedent with the Marylend 10a. Stata 10d. Insida City Limits 10b. County 10c. City, Town or Location pernit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic avent, the Medical Examines must be notified as Yes 2□No Director 10e. Street end Number 10g. Citizan of What Country? Funeral JNam Was Decedant Evar In U.S. Armed Forcas? Race - Amarican Indien, Bleck, Whita, etc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, spacify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 Nevar Merried 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify. þ 3 Widowed 4 □ Divorced lack Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/I Elamentary/Secondary (0-12) Collaga (1-4or 5+) 12th grade 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maidan Şumema) Be 2 + rank HOTTIC 19a. informant's Name/Ralationship (Typa, Print) 19b. Melling Addrass (Straat end Number or Rural Routa Number City or Town, Stata, Zip Coda) HVV) c 20a. Method of Disposition 20c. Location - City or Town, Stata 20b. Place of Disposition (Name of cametary, crametory or other place) Data 1 Burial 2 Cramelion 3 Removal from Stete 4 Donation 5 Othar (Specify) Canota Stockton 21. Signature of Funaral Sarvice Licansia 22. Nama end Addrass of Facility envic 5mith 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac shock, or heef failure. List only one cause on each line. Pocamo Approximele Intarval Batwaen Onsat end Daath **Physician** Immediete Causa (Final diseesa or condition rasulting in death) /Medical DRONARY ARIFRY KEW YRS Examiner Due to (or es e consequance of): Examiner certificate be executed ettending physician end for use as the burial-transit Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consaquance of): Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of): been signed by the should be detached Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown þ 24b, Wara autopsy findings available prior to Completed 24a. Wes an autopsy periormed? completion of cause of deeth? hes 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No this certificate Division of Vital or Attending Physician: effer death. Director: After this certifica funeral director, 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4☐ Nursing Homa 5X Rasidenca 6 ☐ Other (Specify) Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Mennar of Daath 28e. Dete of Injury (Month, Dey Year) 28b. Tima of 28c. fnjury at Work? 28d. Dascribe how injury occurred 1 Netural 5 Panding Invastigation 1 Yes 2 No 2 Accident To the Hospital or Atterwithin 24 hours efter dea To the Funeral Director completely filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Piaca of Injury - At home, farm, straet, factory, offica building, atc. (Specify) 4 ☐ Homicida 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha time, dete end plece, end due to the ceuse(s) end manner es stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha time, deta and place, end due to the cause(s) and menner stated. edicai 29a. Cartifiar (Check only one) 29b. Signatura and title of cartifiar 29c. License number 29d. Data signed (Month, Day, Year) 05-12-00 30. Nama and address of person who complated cause of death (Itam 23e) (Type, Print)

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32. Registrar's Signatura

State

Registrar

31. Dela filad (Month, Day, Yaar)

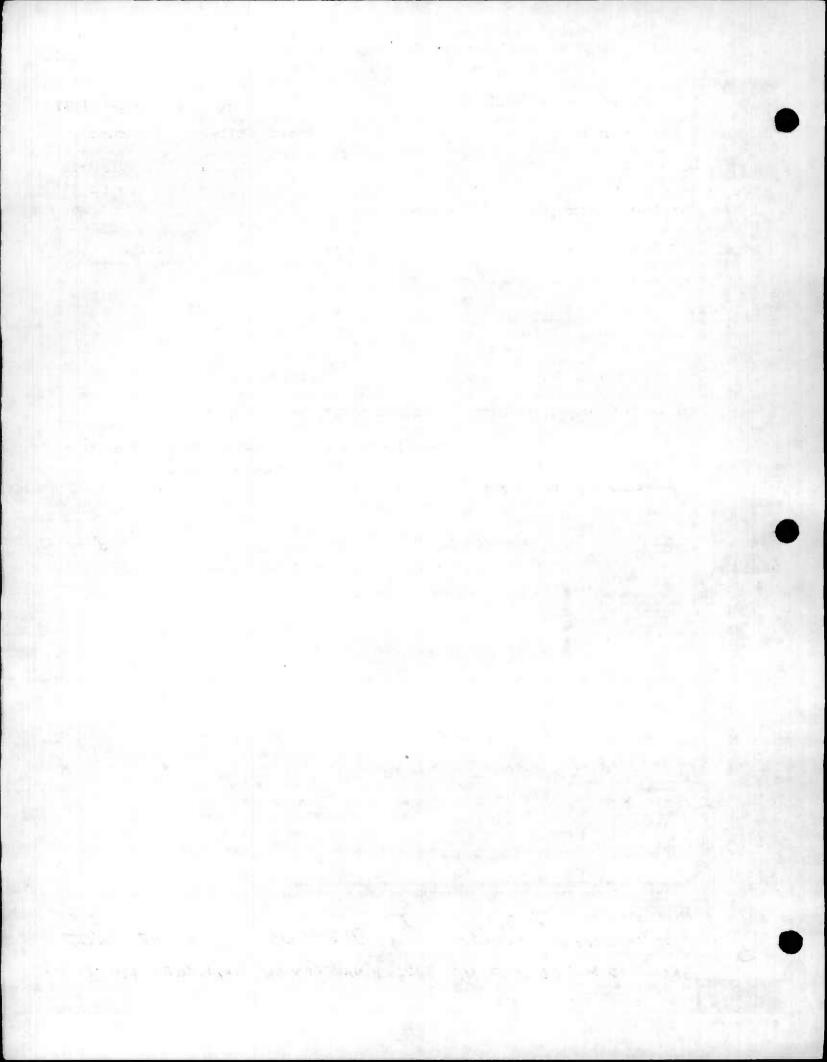
MAY 1 2 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month Physician BETTLE Η BRITTINGHAM 11:53 PM May 2000 16 /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Pocomoke City Hartley Hall Worcester 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) June 10, 1932 7. Age (In vrs. lest birthdev) 9. Birthplece (State or Foreign **Funeral** Months Deys Hours 1 □ M 2 K F 214-32-0199 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours ettar death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28. *** 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Worcester Pocomoke City 1 XYas 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 507 Cedar Street 21851 U.S.A. Funeral 12. Wes Dacedent Ever in U,S. Armed Forces? 14. Race - Amaricen Indlen, Bleck, White, etc. 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Maryland 21215-0020 1 Yes 2 No Specify. Specify: 3 ₩ Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Store clerk 11 retail 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Ed Tom Hickman, Sr. Vesta Lee Justice 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ed Tom Hickmam, Jr./brother Atlantic Road, Assawoman, VA 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlat 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Wattsville Cemetery 5-18-00 Wattsville, VA 22. Nama and Address of Fecility Fox Funeral Home e of Funeral Service Licensee P O Box 278--Temperanceville, VA 23442-0278 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** a Small Cell Carcinoma of Lungs
with Due to (or es e ponsequence of):

mitaslasis to Pelicis and alcanols Immediete Ceuse (Final diseese or condition resulting in death) /Medical 4/25 Examiner Examiner physician and s the buriel-transit Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): requires that the death certificate be axec Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): ettending 0 Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 99 þ 24b. Were eutopsy findings eveileble prior to completion of ceusa of deeth? Completed 24e. Was en eutopsy performed? peeu page 2 hes cartificate 1 Yas 2 No 1 ☐ Yes 2 12 No Division of Vital Be 25. Was case referred to medicel exeminer? 28. Piece of Death (Check only one) Hospitel: 2 1 Yas 2 No Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Tima of Injury 28d. Describe how Injury occurred ne Hospital or Attending P in 24 hours after death. The Funeral Director: After t pletely filled in by the funera 28c. Injury at Work? After 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Streat end Number or Rurel Routa Number, City or Town, Stete) 4 Homicide 29a. Certifier 176 Certifying Physician: To the best of my knowledge, daeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.
2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated. Medical pletely (Check only one) To the Within To the 20b, Signature and title of certifier 29c. Licansa number 29d, Date signed (Month, Dev. Yaer) Elgered My. Name and admess of parson who completed ceuse of death (Item 23a) (Type, Print) USO MD; 5 32 Aegistrer's Signature GREGORIO M. BELLOSO 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Dete filed (Month, Dey, Year) State 18 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7250 Amend #17,18,5/17/2000, BMW, Montg. Co. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY Month Dey **Physician** 2000 GRACE NANCY BRADBURY 14, 4:10PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Hours Months 1□M 2□F YOUNGSTOWN, OHIO 299-24-5693 72 Vre Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No 288-4 Director MARYLAND MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. Idher than "natural", or herre 25e or ent, the Medical Examiner must be. Nerns 23s or Funeral 5101 RIVER ROAD 20814 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: WHITE Maryland 21215-0020 1 Yes 2 No Specify: Specify: ğ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REALTOR REAL ESTATE permit. Pages 1 and 2 should be file Deportment of Health and Mantal Hy Important! if Item 27 is marriad other ony Injury or other traumatic event other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 86 HERMAN ZEVE SIGMANUEL EDITH ZEVE HOROWITZ HORWITZ. 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) RICHARD SCOTT LUPIN (SON) 10203 SWEETWOOD AVE, ROCKVILLE, MARYLAND 20850 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 ElCremation 3 ☐ Removel from State CHESAPEAKE CREMATORY 4 Donation 5 Other (Specify) BELTSVILLE, MARYLAND 5-17-00 rvice Licensee 22. Name and Address of Facility RAPP FUNERAL & CREMATION SERVICE 933 GIST AVE. SILVER SPRING, MARYLAND 20918 22. Name and Address of Facility 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner May 14,2 Due to (or as a consequence of): Examiner physicien and a the burlai-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of) USA 88 1 i signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes Z No 3 Probably 4 Unknown þ icate has been sig 7, page 2 should b 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was en autopsy SILING 1 Yes certificate Vital Attending Physicien: director. 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To ō this After this funeral o 27. Manner of C 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Division Matural 5 Pending after deeth.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident investigation 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide ò To the Hospital of within 24 hours at To the Funerel D completely filled I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signeture and title of certific 29c. License number 29d. Date signed (Myinth, Day, Year) 18 mmy

State Registrar

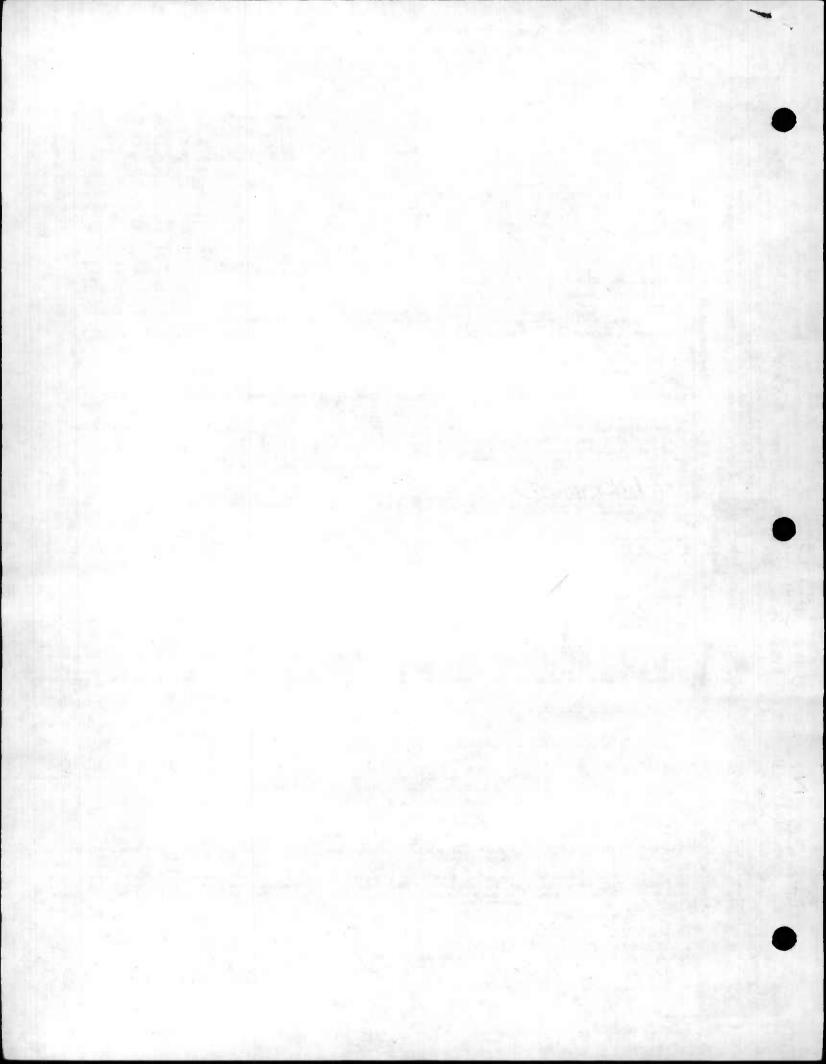
31. Date filed (Month, Day, Year)

2000

16

eted cause of death (Item 23a) (Type, Print)

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Duane Brand, Sr. May 17, 2000 3:02 PM /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring 1301 Mill Grove Place Montgomery 8. Data of Birth (Month, Day, Year) Oct. 23,] 5. Social Sacurity Number If Undar 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Birthplace (Stata or Foreign Country) **Funeral** Days 1♥ M 2□ F Months Hours 75 Yrs. 481 20 4293 Director Iowa Usual Rasidence of Decedant 10a. Stata Show 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No **Funeral Director** Maryland Montgomery Silver Spring 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1301 Mill Grove Place 20905 United States Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indian. Black, Whita, atc. Armed Forces r
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Datas: WW II filed within 72 hours after 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed by 3 ₩idowed 4 Divorced 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiena. Elemantary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Heelih and Mental Hygien
Important: If them 27 is marked other th
any Injury or other treumatic event, the
DDGS. 12 Business Owner Auto Body Repair 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Charles Brand Marion Barr 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Duane C. Brand, Jr. / Son 3524 Northshire Lane, Bowie, MD 20716 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stafa May 19, Chesapeake Crematory, Inc. 4 ☐ Donetion 5 ☐ Othar (Specify) Beltsville, MD 2000 Rapp Funeral and Cremation Services Rapp Funeral and Cremation Services Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD Stephen D. Lohrmann P.A.

Stephen D. Lohrmann P.A.

933 Gist Ave., Silver Spring

23a. Part. Enfer the disease, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feiture. List only one cause on each line. 20910 Approximata fntervat Between Onset and Death **Physician** Immediata Cause (Finel disaase or condition rasulting in death) /Medical 2710 cance Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transi Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in daath) Lasf Dua to (or as a consequence of): P.O. Box 68760, Dua to (or as a consequence of) Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy peeu 1 Yas 2 No

The few requires that the death certificate be executed Records, director, page 2 should be certificate has of Vital or Attending Physician: this funeral After Division e Hospital or Attendir n 24 hours after death. Ne Funerel Director: death. the In by

Medical within 2 0

Certification: To

State Registrar 29b. Signature and fitte of certifier

25. Was case reterred to medical

5 Pending

invastigetion

6 Could not be datamined

Hen

1 Yas 2 No

27. Menner of Deeth

DENatural

2 Accidant

4 ☐ Homicide

(Check only one)

DAnna

31. Dete filed (Month, Day, Year) MAY 19

3 Suicide

29a. Certifier

as

Hospitel: 1 Inpatient

28a. Deta of Injury (Month, Dey Year)

29c. Licansa number

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

Read (e

26. Place of Deeth (Check only one)

1 Yes

28d. Dascribe how injury occurred

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basts of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print)

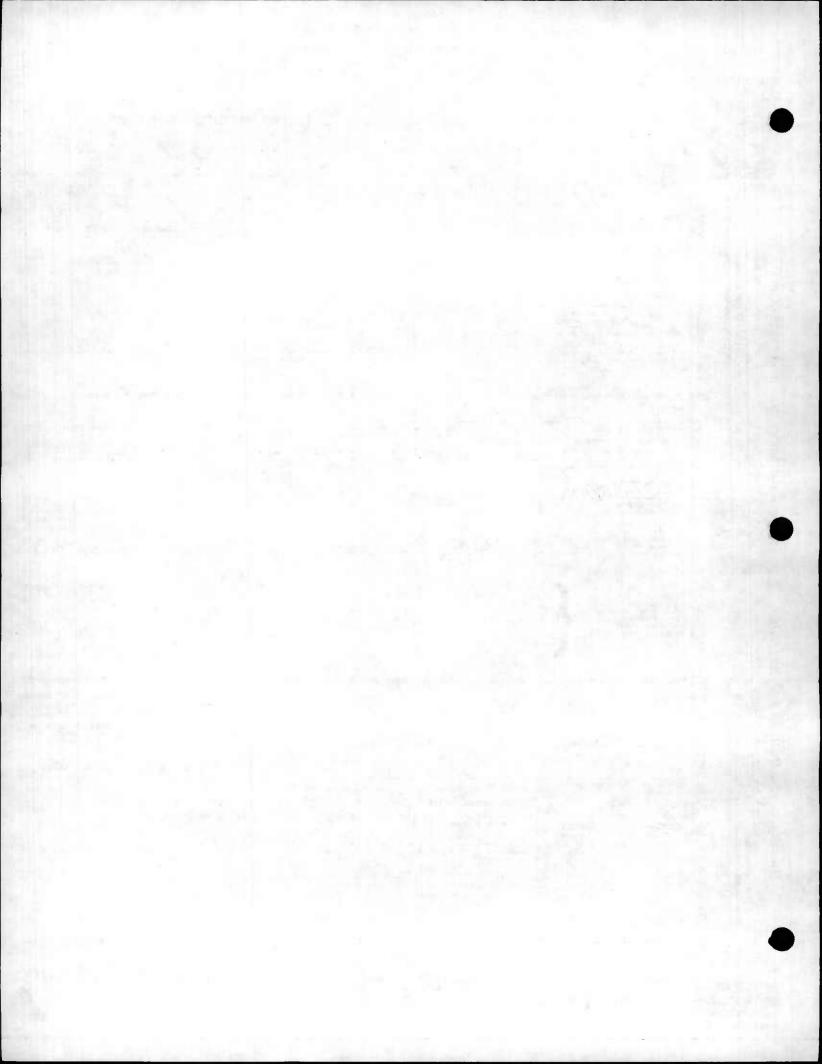
32. Pégistrar's Signatura 2000 beneva

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2 ER/Outpatient 3 DOA

28b. Tima of

28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

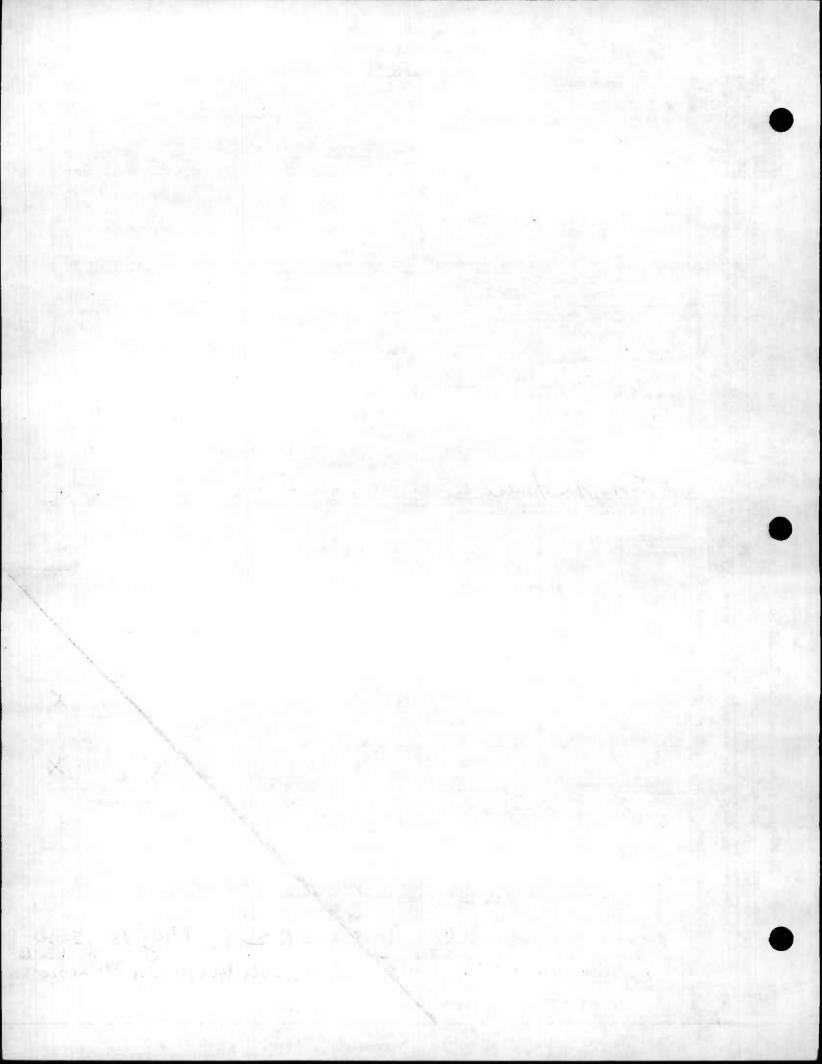


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Salle C. Brisbane May 17, 4b. City, Town, or Location of Death 2000 2:15 am /Medical 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Manor Care- Wheaton Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec 22, 1916

8. Birthplace (State or Foreign Country)
North Carolina 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 10 M 20XF 83 Yrs. Director 578-07-6164 Usuel Residence of Decedent 10c. City, Town or Location Would 10a State 10b. County 10d. Inside City Limits illed within 72 hours after death with the Maryla. Hygiene. Hydiene. Whysiene. Wher then 23s or 28e-f show with the Medical Exercities must be notified as 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1701 Mayhew Drive 20902 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Stetus Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Baitimore, Maryland 21215-0020 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: if tem 27 is marked other that any injury or other treumatic event, that page. 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be 2 Charles C. Ray Allie Parrish 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Brisbane/ Husband 1701 Mayhew Drive, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 5/24/ 1 Buriel 2 □ Cremetion 3 □ Removel from State Arlington National Cemetery 2000 Arlington, VA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licer tune 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediete Cause (Final diseese or condition resulting in deeth) /Medical enmore wee Examiner Due to for as a consequence of: physician and s the burial-transit cartificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): use as tha 23b. Did tobacco usa contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed by t 2 should be detach 3 Probably 4 Unknown 1 Yas 2 No Records. by 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1□ Yes 200No 1 Yes 2 No certificate Division of Vitai f or Attending Physician: after death. Director: After this certifica 25. Wes case referred to medical Be 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined n 24 hours after der Ne Funerei Director bletaly filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Cartifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Ruckville 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eseanch BLVD Sute MENDHIR 31. Dete filed (Month, Day, Year) State Renter Registrar 2000



State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edna May 14,2000 W. Briscoe 12:25 P.M /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3612 Cherryvale Drive Beltsville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) May 04,1924 9. Birthpleca (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs 218-34-5379 76 Director Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No MD Prince George's Beltsville 10e Street and Number 10f Zin Code 10g. Citizen of What Country? i United States of America 3612 Cherryvale Drive 20705 Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Registered Nurse Nursing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 89 Charles Wainwright Grace Woodbury To 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) John E. Briscoe / Son 6522 Coldstream Drive Pasadena, Texas 20a. Method of Disposition 20b. Place of Disposition (Nema of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1X Burial 2 ☐ Cramation 3 ☐ Removal from State 5/18/00 Parklawn Memorial Park Rockville, Maryland 4 Donatie - 5 □ Othar (Specify) 22. Nama and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signatuur of Funeral Sen 11800 New Hampshire Ave. Silver Spring, MD 20904 r complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Imm distriction disease or condition rasulting in death) Metastatic carcinoma 5 1/2 yrs.Examiner Due to (or as a consequenca of): Examiner physician and s the bunal-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or as a consequenca of): USB Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. the the signed by ti 1 Yes 2 No 3 Probably 4 Unknown Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? should l 24e. Was an autopsy performed? Completed has pege 1 ☐ Yes 2 DONo 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? After 1 Naturat 5 Pending investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, lactory, offica building, etc. (Specify) 4 \ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or Investigation, in my opinion, death occurred at the time, dete and plece, and dua to the cause(s) and menner stated. edical 29a. Certifier (Check only one) 29b. Signature 29c. Licensa number 29d. Date signed (Month, Dey, Year) and title of certife

State Registrar

9707 Medical Center Drive, #300, Rockville, Maryland 20850 31. Date filed (Month, Dey, Year) MAY 17 2000

30. Nama and address of person v

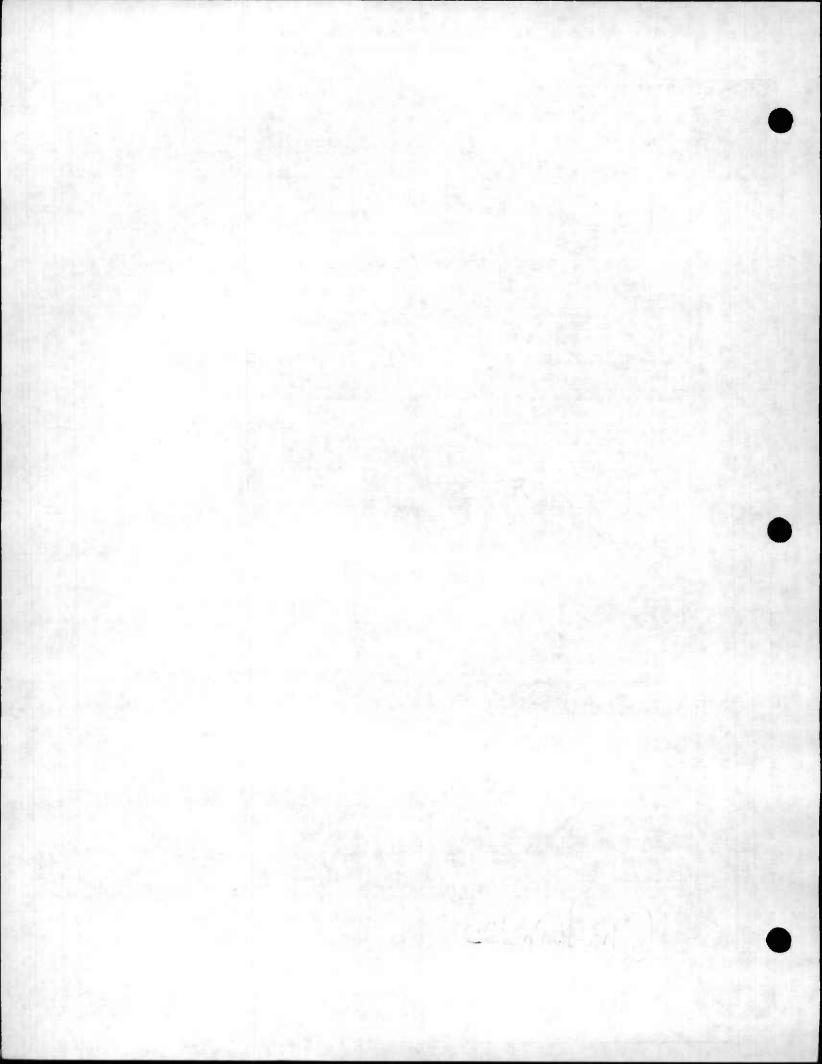
Ralph Boccia, M.D.

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

D29675

May 16, 2000



State of Maryland / Department of Health and Mental Hygiene 7254 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month 3. Time of Death **Physician** Kenneth Cloukey 2000 0835 05 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Data of Birth (Month, Day, Year) August 5, 1915 Birthplace (State or Foreign Country)
 Wisconsin 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Yrs Director 164-16 -1948 Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Annapolis or 28a-f Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 102 South Haven Road 21401 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yas 2 □ No If Yes, Giva Year or Dates: 1942—1946 'natural', or hams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11. Marital Status Black, Whita, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Civil Service U.S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked other any fillury or other treumstic event abos. 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Homer Cloukey Ola Halsted 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Elinor C. Cloukey/Wife 102 South Haven Road Annapolis, Maryland 21401 20b. Place of Disposition (Name of paratary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removel from State
4 ☐ Donation 5 ☐ Other (Specify) Fromsville Veterans Cemetery 05-22-00 Crownsville, Maryland 21. Signature of Funeral Se 22. Nama and Addrass of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Maryland 21401 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Part1. Enter the disease, or com-shock, or heart feilura. List only Approximata Intervel Between Onset and Deeth **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical Examiner Due to (or as a consequence of): hemorrhage Physician/Medical Examiner Massive physician end s the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown arten disease, chronic Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 ☐ Yas 2 No 8 25. Was casa refarred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No this. After this 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 (Matural 5 Pending death. 1 Yes 2 No investigation 2 Accident To the Hospital or Attendi within 24 hours effer death To the Funerel Director; A completely filled in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide tic Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D50954 MD Breau ho completed causa of death (Item 23a) (Type, Print) 30. Nama and address of person w Suite 235 Annapolis, MD 21401 Brian J. Su 600 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Registrar MAY 1 9 2000

DHMH 16 Rev 6/95

CONTRACTOR SOUNDS SE VINE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decadent's Name (First, Middle, Last) 3. Time of Deeth CAmpbell MAY **Physician** Cobert 2215 Leland 15 2000 /Medical 4a Facility Neme (If not institution, give street end number)
594 Shove Acres 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Shore 7. Age (In yrs. last birthday) | If Under 1 Yaar | If Under 24 Hrs. | 8. Dete of Birth Months | Deys | Hours | Min. | May 2, 1932 5. Sociel Security Number Birthpleca (Stata or Foreign Country) **Funeral** 12 M 20 F 181-24-6637 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Arnold 1 TYes 24 No Anne Arundel Director Street and Number 10g. Citizen of What Country? 594 Shore Acres Road 21012 r than "natural", or items 23e or the Medical Exeminer must be USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1.2XYes 2.□No 1950— If Yes, Give 1953 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Slack, White, etc. 1 Never Married 20€ Married White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Westinghouse 7 is marked other traumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental H Oliver Ronald Campbell Hazel Coursen permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 20 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 594 Shore Acres Road, Arnold, MD 21012 Miriam Campbell/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20s. Method of Disposition May Date 17 20c. Location - City or Town, State 1 ☐ Surial 2 Securation 3 ☐ Removal from State 4 ☐ Bonation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory 21. Signature of Fungral Service Licens 22 Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 over the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Wound, Hend · (OUNShot Examiner Due to for as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exa physician s the burla Division of Vital Records, P.O. Box 68760, 2 Physician/Medical Due to (or as a consequence of): 台 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by a d be detach 1 Tes 2 No 3 Probably 4 Whiknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy director, page 2 r T□Yes 2000 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Pisce of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Yes 2□ No 27. Manner of Death Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the same 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Affer 1 [Natural 5 Pending Attending death. 5/15/00 2210 M 1□ 28a. Place of Injury - At home, farm, street, factory, office building, etc, (Specify) 1 Yes 2 No Dhot Self investigation 2 D Accident or Attend after deal Director: 3 Suicide 4 Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours at To the Funeral Di completely filled it tome gruold 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) and manner es steted.

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MAY 1.8 2000

32. Registrar's Signeture

DHMH 16 Rev 6/95

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year **Physician** Mary Ellen Cross May 12 2000 1:20 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1479 Grandview Road Arnold Anne Arundel If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Nov. 19, 1919 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (in yrs. last birthday) **Funeral** Hours Months Days 1□M 2QF Yrs 80 Director 288-18-6636 Ohio Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s4 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2578 Misty Ridge Cove 21401 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or item eny injury or other traumatic event, the Medical Examina 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Ag Specify. 3℃ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Social Worker County Government 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Be 2 Anola Rolli Lester R. Shroyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Carolyn Bialousz / daughter Arnold, MD. 1479 Grandview Road 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Burial 2 Ki Cremetion 3 ☐ Removal from State 5-15-00 Ft. Brentwood, MD. 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 3months disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last and Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 3.5 USB 0 signed by the a d be datached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? has 1 ☐ Yes 2 No 2 No director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) daughter's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA home funeral 28d. Describe how injury occurred 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Naturel 2 Accident 5 Pending investigation 1 TYes 2 □ No death. i or Attend aftar death Director: / 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours To the Funeral Completely filled 29a. Certifier Ty-Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner as stated.

The dical Examiner: On the basis of examinetion and/or investigation, in my coinion, death occurred at the time, date and place, and due to the or edical dical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) one 29d. Date signed (Month, Day, Year) 29b. Signeture and tille of d 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Annapolis 21401 900 Bes

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State

Registrar

MD

32 Registrar's Signature

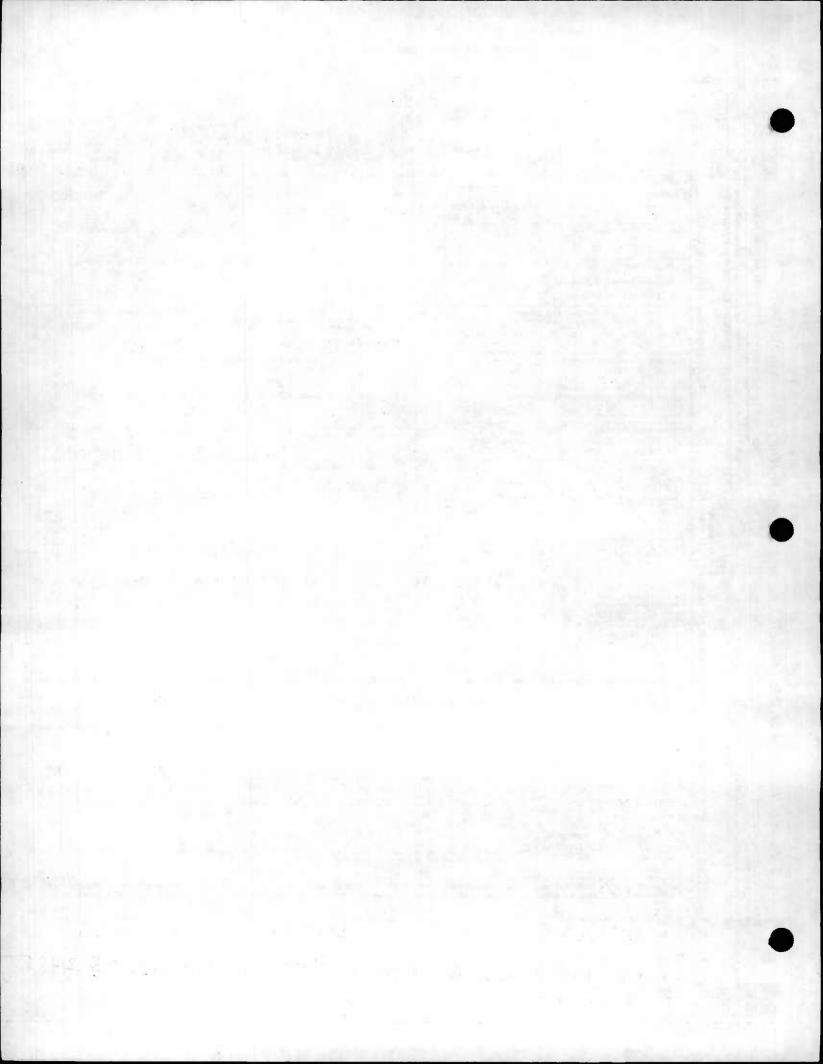
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31. Date filed (Month, Day, Yar)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Examiner	4a Facility No	ama (If not institution, g	give street and number)			4	lb. City, Town, or Lo	ocation of Death		
	Gene	sis Elder (Care				Brooklyr	Park	Anne A	rundel
Funeral Director		8-3742	Sex 7. Age	(In yrs. last bird	Yrs. If Unc	der 1 Yaar ns Days	If Under 24 Hrs. Hours Min.	8. Data of Birt (Month, Da) Sept. 1	r, Year)	Birthplace (State or Fore Country) Orth Caroli
1	10a. State	nce of Decedent 10b. County		10c. City, Town	or Location					10d. Inside City Lim
or 28a-1 sho be notified a	MD	Anı	ne Arundel	Linthi	icum					1 ☐ Yes 2X
unibe or 2		ansion Road	1			Zip Code 2109		20-2	10g. Citizen of What USA	
Examinar of the	3 DWidon	atus Married 2 Married Married 4 Divorced	12. Wes Decedent II Armed Forces? 1			pecify Cuba 2 No	ispanic Origin? (Sp nn, Mexican, Puerto Specify:	ecify Yes or No- Rican, atc.)	14. Race - A Black, W Specify:	marican Indian, Thita, etc. White
disal disal		15. Decedent's (Specify only highest of	Education arade completed)	16a.	Decedent's Us	sual Occup	ation during most of work f)	ing	16b. Kind of Busina	ss/industry
t, the Medical.	Elementary	/Secondary (0-12)	College (1-4or 5	+)					0 11	
N E E .	17 Enthada h	6	ed)		Home	Maker		a (First AC da)	Own Home	
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To To		emens Lowm			44 14		Alpha N		0.	Name of the last o
The state of the s		nt's Name/Relationship McDonal	(Type, Print) d - daughte:		_				r, City or Town, State	e, Zip Code)
Der Der	20a. Method		a – daugnce.				l., Linthi	Data MC		or Town State
lury or o	1 🕅 Buria 4 □ Dona	al 2 Cremetion 3 ation 5 Other (Spec			Disposition (A y, crematory o vridge		ial Pk.	5/17/00	20c. Location - City Elkridge	
any in	21. Signeture	of Fungral Service Lie	Leter m	00843	Garv	L. Ka	ss of Fecility ufman Fur ngton Blv	neral Ho /d., Elk	me @ Meado ridge, Md	wridge MP, I 21075
	23a. Part1. E shock, s	ryley the disease, or con heart feilure. List on	mplications that caused ly ona cause on each lin	the death. Do n						Approximata Intervel Between
sician	(mm. first 2	(5:			. 0.		0 1 .	4.		Onsat and Deeth
ledical aminer	Immediate Co disease or co resulting in de	ndition	a ch	Lovic	- AC	ria	I fil	rillal	ion	विक्रिश्व
- I		,		Due to (or as a c	consequence o	of):			000	2040
ig E			b. HU	perte	win		work our	nseula	1 Distease	2 doys
n and tel-transit Examine	Sequentially I	ist conditions, g to immediate Underlying ise or injury	0	Puel to (or as a c	consequence o	đ):				
as the bur Aedical	resulting in de	events	c	Due to (or es a c	onsequence o	():				
d for	Part II. Other	significant conditions	contributing to death bu	t not resulting in	the underlying	n causa niv	en in Pert I	23b. Did t	obacco use contrib	ute to the causa of de
					and anosity in	y out ou gro		101		Probably 4 Unkr
ned by the attendir e detached for use y Physician/h								24a. Was	an autopsy 24 med?	b. Wara autopsy tindin available prior to
b va								репо		completion of causa of deeth?
has been signed at 2 should be dimpleted by								perior	es 200 No	
has been signed at 2 should be dimpleted by		refarred to medical					26. Place of Deat	101	/ \	of deeth?
his cartificate has been signed if director, page 2 should be d	25. Was case axaminer 1 Yes	25 No	Hospital: 1 Inpatie		·		er: 4 Nursing Ho	1 0 N	ence 6 Other (S	of deeth? 1 ☐ Yes 2 No
his cartificate has been signed if director, page 2 should be d	25. Was case axaminer 1 Yes 27. Manner of 1 Natura	Death 5 Pending	28a. Data of Injur (Month, Day		ima of njury	28c. Injun	er: 4 Nursing Ho	1 0 N	ne)	of deeth? 1 ☐ Yes 2 No
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at Director: After this cardificate has been signed in by the funeral director, page 2 should be director. To Be Completed by	25. Was case axaminer? 1 Yes 27. Manner of 1 Nature 2 Accid 3 Suicid 4 Homi 29a. Certifier (Check on one)	No Death all 5 Pending investigate de 6 Could not detarmine	28a. Data of Injur (Month, Day 28a. Place of Injur building, etc. Physician: To the best of arminer: On the basis of	Year) 28b. Tir ny - At homa, fai (Specify) (my knowledge, examination and	ima of niury M mm, street, fact death occurre st/or investigation 2	28c. Injun Word 1 1 ory, office ad at the timon, in my of the control of the cont	er: 4 Nursing Ho	h (Check only or ma 5 Reside 28d. Describe he City or Toward and dua to that ared at the time, or	ence 6 Other (Sow injury occurred Street and Number or In, State) Lause(s) and mannariate and plece, end of the lause (South Control of the	of deeth? 1 Ves 2 No Specify) Rural Route Number, r as stated. due to the cause(s) onth, Day, Year}



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2000 5:01A.M. Grace Elizabeth Chalfant 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Death Harford Memorial Hospital Havre de Grace Harford if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 19, 1925 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months 1 □ M 2 18 F Pennsylvania 74 Yrs 176-20-2943 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1⊠ Yes 2 No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Dorsey Street 21001 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Biack, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Preston Viola M. Rhoades 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Chalfant (Son) 415 Dorsey Street, Aberdeen, Maryland 21001 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 5/22/00 West Chester, PA 21. Signature of Fune of Servica Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 ang onnes 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth immediate Cause (Final disease or condition resulting in death) OCOCCA Due to (or es e consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): thet initieted events resulting in deeth) Last Due to (or as a consequence of)

Physician /Medical Examiner

use as the buriel-transit

ettending physician and

been signed by the should be deteched

After this certificate hes

director,

funeral

in by

Medical

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

24 hours a

To the I

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

P

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other treumatic event, the Medical Example mast be noritined at once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner λq Completed Be P Certification:

The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. reluchan

23b. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown 10 Y00

24a. Was an autopsy performed? 20 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Neturei 2 Accident 5 Pending investigation 1 Yes 2 No

6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number

Hospital?

29d. Date signed (Month, Dey, Year)

cause of death (Item 23a) (Type, Print)

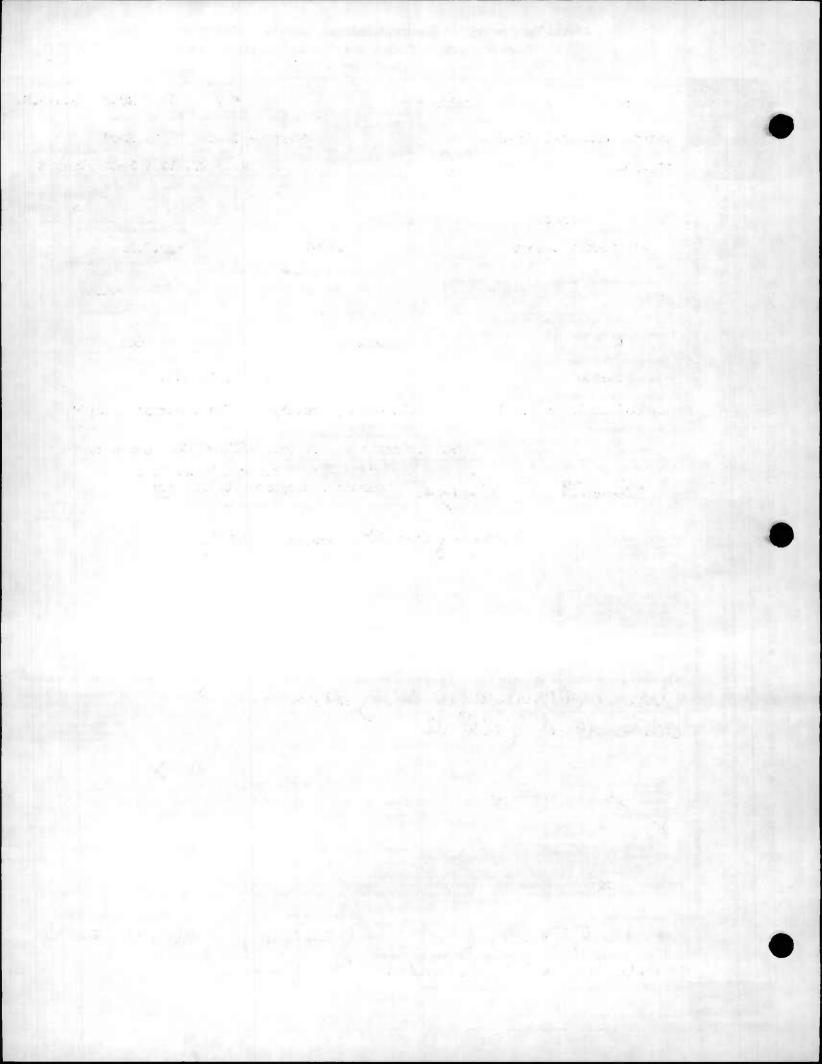
del Was

31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Dey Month **Physician** Shirley Ann Claburn 11 May 2000 6:07 pm /Medical 4a. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel
If Under 24 Hrs.
Hours Min. Laurel Regional Hospital Prince George's If Under 1 Year 5. Social Sacurity Numb 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foraign Country) **Funeral** Days Months 1□M AFF Vre-Director 215-44-4787 48 June 30, 1951 Florida Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Md. Anne Arundel 288-1 Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 47 South Bruce Street items 23a 20724 U.S.A. Funeral 12. Was Decedant Ever in U,S Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours effer 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2√2 No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pernit. Pages 1 end 2 should be filed withir Department of Health end Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Bookkeeper Auto Parts 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Lee Claburn Dorothy Whitted 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Ann Guile Daughter 8519 Mulberry Street Laurel, Maryland 20707 20b. Plece of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State Donation 5 Other (Specify) May 16, 2000 Cedar Hill Cemetery Suitland, Maryland 21. Signature of Funaral Sarvice Licensaa 22. Name and Address of Facility Donaldson Funeral Home, P.A. / MOO770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Betwaen Onset and Deeth **Physician** tmmediate Cause (Finel disease or condition resulting in death) /Medical Respiratory Failure Examiner months Due to (or es e consequence of): Metastatic Lung Cancer months bunial-transi Exami and Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consaquanca of): ettending physician for use as the buria Box 68760. certificete be Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 3 Probably 4 Unknown 1 Yes 2 No The law requires that Records, ģ 8 24b. Ware autopsy findings available prior to Completed 24a. Was an autopsy peed complation of ceusa of deeth? page 2 s certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Mospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

27. Menner of Death 70 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Straet and Numbar or Rural Routa Number, City or Town, State) 28a. Placa of fnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homlcide To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as steted.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Vithin 2 and manner stated. nd title o 29b. Signature 29c. License numbar 29d. Data signed (Month, Day, Year) 0 May 12, 2000

death (Item 23a) (Type, Print)

#116

souks,

Laurel, Maryland

20708

Mallard Drive

State Registrar 30. Na

he and address of person who completed ceuse d

1 5 2000

9811

32. Registrar's Signature

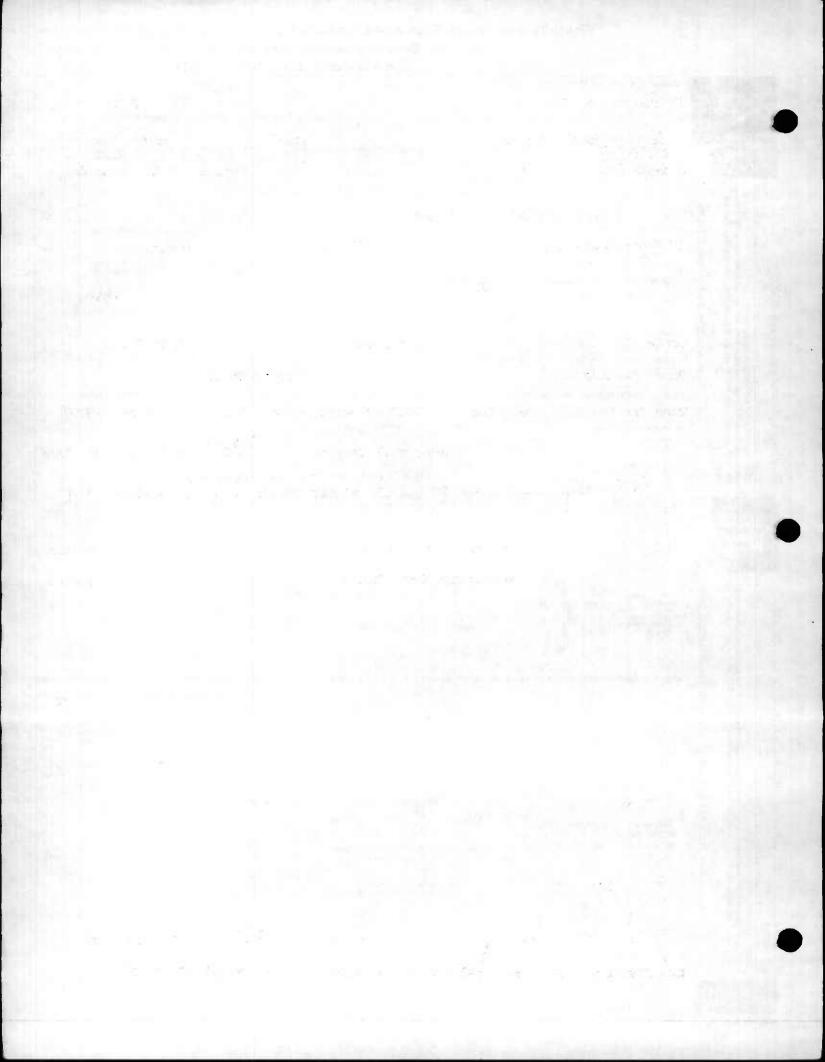
Gdy Steinberg, MD

MAY

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

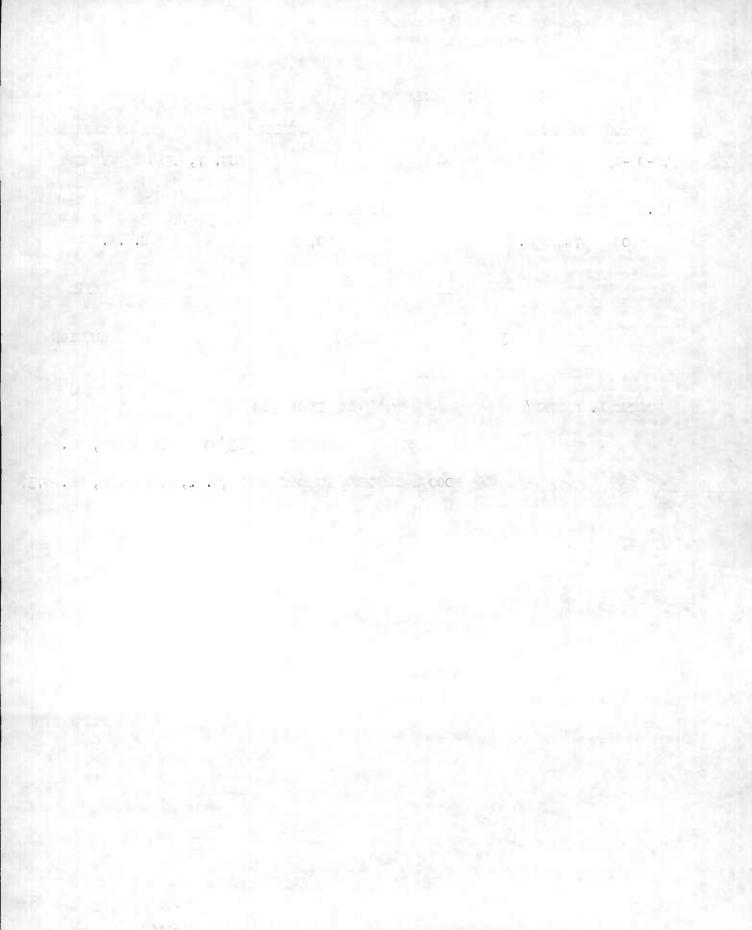
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State of Maryland / Department of Health and Mental Hygiene

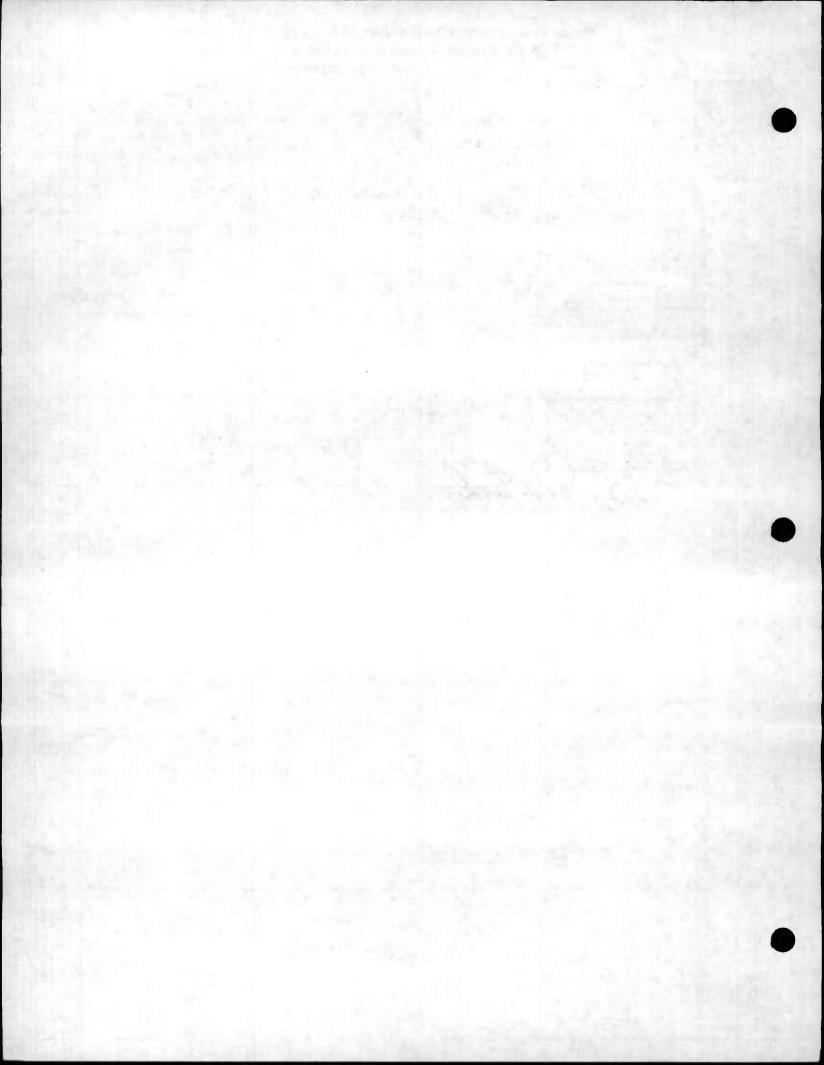
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- "	1. Decedent's Name (First, Middle, Last))	1000		2. Date of Deeth		3. Time of Death
Physician /Medical	JAM	ES COOK	CALFEE		Month	Dey 2000	6:25pm
Examiner	4a Facility Name (If not institution, giva	street and number)		4b. City, Town, or	Location of Daath	4c. County of Deet	
	DOCTORS HOSPIT	AL		LANHAM		PRINCE	GEORGES
Funeral	5. Sociel Security Number 6. Sex	7. Age (In yrs	: last birthday) If Und Month	er 1 Year If Under 24 Hrs	8. Date of Birth		hplace (State or Foreign
Director	579-09-1555	[M 2□F 8	1 Yrs.	S Days Hours Mill	AUG. 7,		YOMING
Man A	10a. State 10b. County	10c. C	ity, Town or Location				10d. fnside City Limits
to the	MD. PRINCE G	EORGES	HYA	PTSVILLE			1∭ Yes 2□ No
ith with the Marylar 23a or 23a-f show ust be northed at rai Director	10e. Street and Number	1202102-10		Zip Code	10	g. Citizen of What Co	ountry?
Sa Sa	2400 57th A	VE.		20785		U.S.A	
r items 23a		12. Was Decedent Ever in i	J.S. 13. Was Dec	edent of Hispanic Origin? (Specify Cuben, Mexican, Puer	Specify Yes or No-	14. Race - Ame	ricen Indian,
72 hours enter death with the Maryland natural", or items 23a or 23a-f show older Examiner must be notified at sted by Funeral Director	1 ☐ Never Marriad 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 M Yas 2 □ No If Yes, Give Yeer or Detes: WW I	1□ Yes	2 ☑ No Specify:	to Micen, etc.)	Black, White Specify:	e, etc. WHITE
ygiene. ber then *natural rt, fre Mexical E.	15. Decedent's Edu (Specify only highest grade	cation	16a Decedent's Us	sual Occupation	deina	6b. Kind of Business/	
pie	Elementary/Secondary (0-12)	Collega (1-4or 5+)	life. DO NOT	vork done during most of wo use retired)	rkii g		
Hygiene. ther then ' ent, the Me.		3	SUP	ERVISOR		CONST	RUCTION
EI E E	17. Fethar's Name (First, Middla, Last)			18. Mother's Na	me (First, Middle, N	laiden Sumame)	
nd Mentel marked o	WALTER	BYRD CA	LFEE		DELORA	ROSE	
	19a. Informent's Name/Relationship (Ty	rpe, Print)	19b. Meiling Addre	ss (Street and Number or R	ural Route Number,	City or Town, State, 2	Zip Code)
D E N D	WALTER L. CALFE	EE/SON	SAME	AS ITEM #1	0		
- + 1	20a. Method of Disposition	20b.	Place of Disposition (A cemetery, crematory of	lame of	Date 2	Oc. Location - City or	Town, Stete
y or	1 ☐ Buriel 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from Stete	CHAMBERS (5/13/00	RIVERDAI	M. M.
in la martin	21. Signature of Funeral Service Lighnse	00		and Address of Fecility	2/13/00	I/T A DI/DAT	ونلا
Department of Popular Information of Important: if its any injury or or on once.	MAN Chan	Merson MO	0091 CHAMBI	ERS FUNERAL H	OMES .P.A.	. RIVERDAI	E. MD. 2073
	23a. Part1. Enter the disease, or compli shock, or heert failure. List only or						Approximate Intervel Between
Physician /Medical Examiner Examiner Examiner	tmmediate Ceuse (Finel disease or condition resulting in death)	MYOCAX Due to COKOMA	O)AL J (or as a consequence o	NFARCTING	795E		
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the shed i	Part II. Other significant conditions con	tributing to death but not re	sulting in the underlying	g cause given in Pert I.	23b. Dfd to	bacco uae contribute	to the causs of deat
igned by the be deteched					1 □ Y	98 2□No 3□P	robably 4 Unkno
should should					24a. Wes en perform	ned?	Were eutopsy findings aveilebie prior to completion of causa of deeth?
rate hes pege 2					1□ Ye	s 2 No	1 ☐ Yes 2 ☐ No
certificate rector, peg	25. Was cese referred to medical			26. Plece of De	ath (Check only on	9)	
r this certifica ral director, p. To Be C	exeminer?	lospitel: 1 Ninpatient 2	□ ER/Outpetient 3□	DOA Other: 4 Nursing	Home 5 ☐ Reside	nce 6 Other (Spe	cify)
deeth. tor: After thi the funeral	27. Menner of Deeth 1 DNaturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe ho	w Injury occurred	
200	3 Suicida 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, fact hify)	ory, office	28f. Location (St. City or Town	reet and Number or Ri , State)	urel Route Number,
Funer Funer leh fill	29e. Certifier TX Certifying Physical (Check only one)	ness. On the begin of everyle	ation andles investigation	ed et the time, date end plec on, in my opinion, death occ	useed at the time de	to and place and du	to the course(c)
0 455	29b. Signature and title of certifier		2	9c. License number	2	d. Date signed (Mont	th, Dey, Year)
Z 90 je	1 12 12 11			17597	7	5.11.07	7
within 2 Complete	1 Manuel Mi		The state of the s	0 20 11		0 1100	
	30. Name and address of person who co	ompleted ceuse of deeth (lite	om 23e) (Type, Print) 7 HANOVEK	259 7 BARKWAY A	TA GREE	NBELT M	4.20770



State of Maryland / Department of Health and Mental Hygiene 0 0 17262

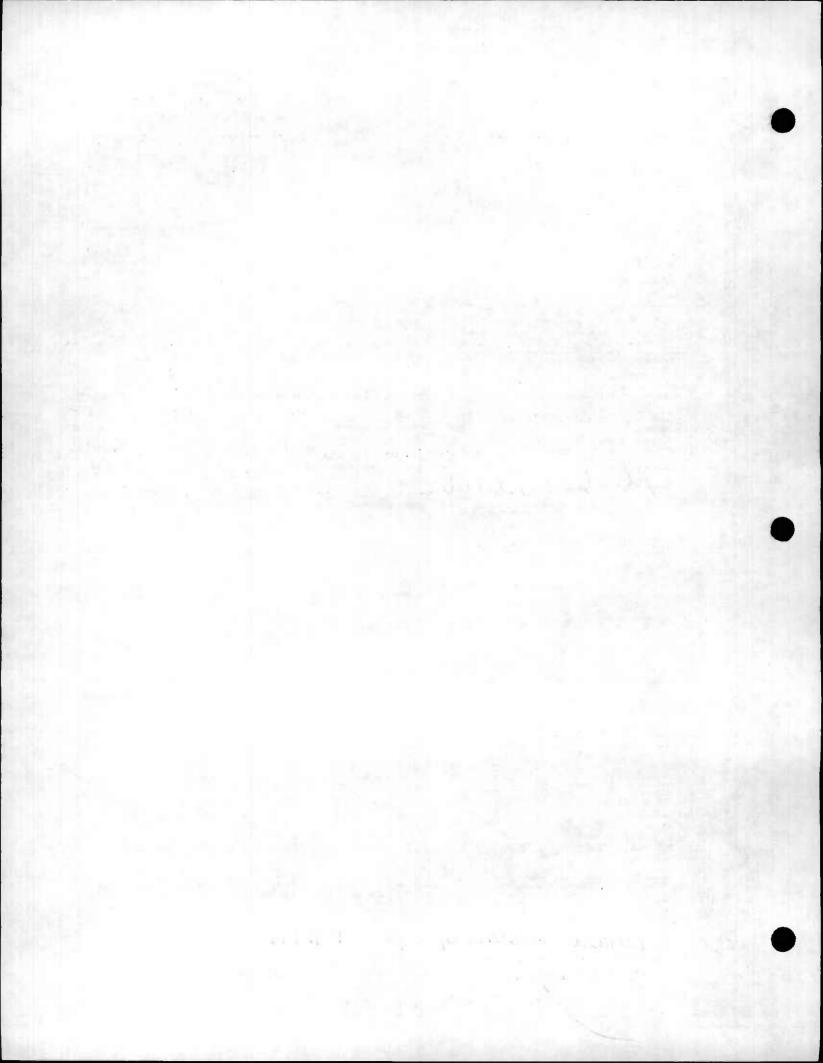
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	1. Decedent's Name (First, Middle	la, Last)		11.	30,137					2. Data of Da		10.4	Vane	3. Time of Death
cian lical	Mark C	olbi	urn							May Month	14	, 20	O O	1:00 A
	4a Facility Name (If not institution	n, give st	reet end nu	m <i>ber)</i>				4b. City, To	own, or Lo	cation of Dea	th 4	c. County	of Death	
	1801 East Je	ffer	rson	St Ap	t. 43	1		Roc	k w 1 1	16		Mon	tgo	mery
1	5. Social Security Number	6. Sex		7. Age (In yrs	. last birthdey,	If Und	er 1 Yaar Days	If Unda Hours	24 Hrs. Min.	8. Data of Bi	irth	(r)	9. Birth	place (State or Foreign
r	092-09-0907	101	M 2 F	8	4 Yrs.					DEC.	4,	1915	Ne	w'York
-	Usual Residence of Decedent 10a. State 10b. County			100 C	lity, Town or L	nontion								10d Jacida Ciby I Imita
									1-					10d. Inside City Limits 12€1¥es 2 No
25		ntgo	omery	7	Rockv									
Director	10e. Street and Number					10f. 2	ip Code					itizen of W		
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5	11. Marital Status		Armed Fo		0,8.	If Yes, sp	edent of I	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	0-		k, Whita,	can indian, , etc.
by Funeral	1 Nevar Married 2 Marr 3 Widowed 4 Divorced		1 ☐ Yes If Yes, Gir Year or D	Ve X	4-41	1 🗆 Yes	2 □ No	Specify				Specify.	TJ 1	hite
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0	17. Father's Name (First, Middle,	Last)				-		18. Moth	er's Name	(First, Middle				
Be C	Isidor		e n					Ida	a Ma	ltz				
6	19a. Informant's Name/Relations	ship (Type	e Print)		19b Meil	ino Addre	ss (Street	end Numt	er or Run	al Route Numb	ber City	or Town	State Zin	Code) 0000
	Evelyn Colbu:													ckville,
	20a. Method of Disposition	- 11/	WIIC		Place of Disp	osition (N	ama of		. 5011	Date Date				own, State
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Lucy Vernon Conway 16, 2000 May 1:35 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery # Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2k F Yrs. 84 Director 219-07-5634 May 16, 1916 Kentucky Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 16632 Alden Avenue 20877 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritai Status Black, White, etc. i Hygiene. other than "natural", or ite 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 Federal Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any Injury or other traumatic eventions. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Stephen Woods Spurlock Lucy 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Conway/Daughter 16632 Alden Avenue, Gaithersburg, Maryland 20877 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. National Mem. Park 5/19/00 Laurel, Maryland 22. Name and Address of Facility
DeVol Funeral Home ure of Funeral Service License 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical 2 days a Sepsis Examiner Due to (or as a consequence of): Physician/Medical Examiner Pneumonia The law requires that the death certificate be executed physician and s the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequenca of): P.O. F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the causs of death? 1 Yee 2 No 3 Probably 4 Unknown s been signed to should be dete Renal Insufficiency, Diabetes Records. P 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an eutopsy Atrial Fibrillation s certificate has t director, page 2 s 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, I 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4⊠ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner es stated 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Puscella Calleton-tron D41794 May 16, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pricilla Callahan-Lyon, M.D., 911 Russell Ave., Gaithersburg, MD. 20877 31. Date filed (Month, Day, Year) 32. Registrer's Signature State MAY 18 2000 come rocks Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Daeth **Physician** 2000 May 18, Marion E. Cullinane 10:25 am /Medical 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice- Casey House Montgomery Rockville If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year, Birthplace (State or Foreign Country) **Funeral** Hours Davs 1□M 20 F Months Yrs. 94 Nov 10, Director 577-12-9734 1905 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 ☐ Yes 2 No Director Maryland | Montgomery "natural", or flams 23s or 28s-f edical Examiner must be notifie Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 9800 Summit Avenue 20895 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after frequential Health and Mental Hygiene. Important if item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examina-1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 DiWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Night Manager NIH Communications 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Thomas O'Connor Elizabeth Creagan 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Marie C. Hollenbeck / Daughter 4513 Roxbury Drive, Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 5/18/00 Alexandria, VA 22. Name and Address of Fecility 21. Signature of Funeral Service Licens Francis J. Collins Funeral Home, Inc. ames 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each shock. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Metastatic Breast Carcinoma 5 years Examiner Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician s the buria Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of) for use as P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown py Records. Completed 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? completion of cause of death? s certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital Attending Physician: 25. Wes case referred to medical examiner? Be 28. Place of Daeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Netural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending death. 1 Yes 2 No 2 Accident investigation Director: / To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edicai 29a. Certifier 1 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. III: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and prainer stated. (Check only

State Registrar

D

29b. Signature and title of certifi

31. Dete filed (Month, Day, Year)

Mark S.

hij addless of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture cherry

MD

19 2000

Godec,

DHMH 16 Rev 6/95

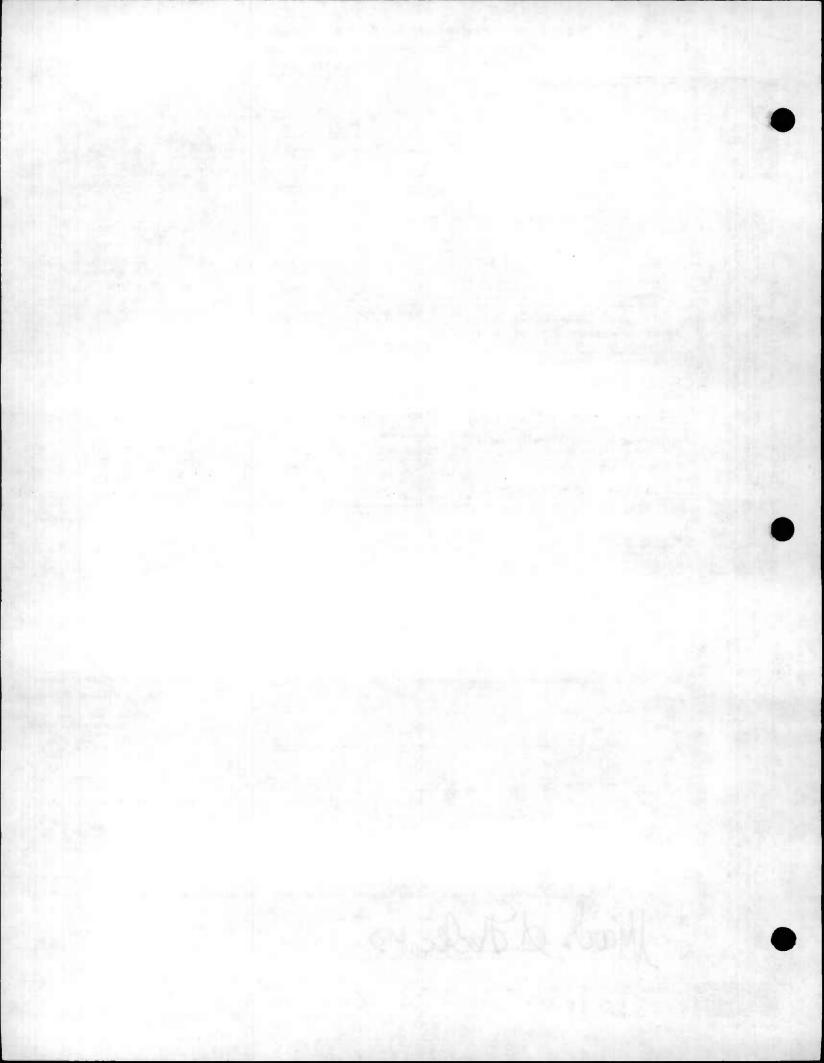
6001 Muncaster Mill Road, Rockville, MD

29c. License number

D 37620

29d. Date signed (Month, Day, Year)

May 18, 2000

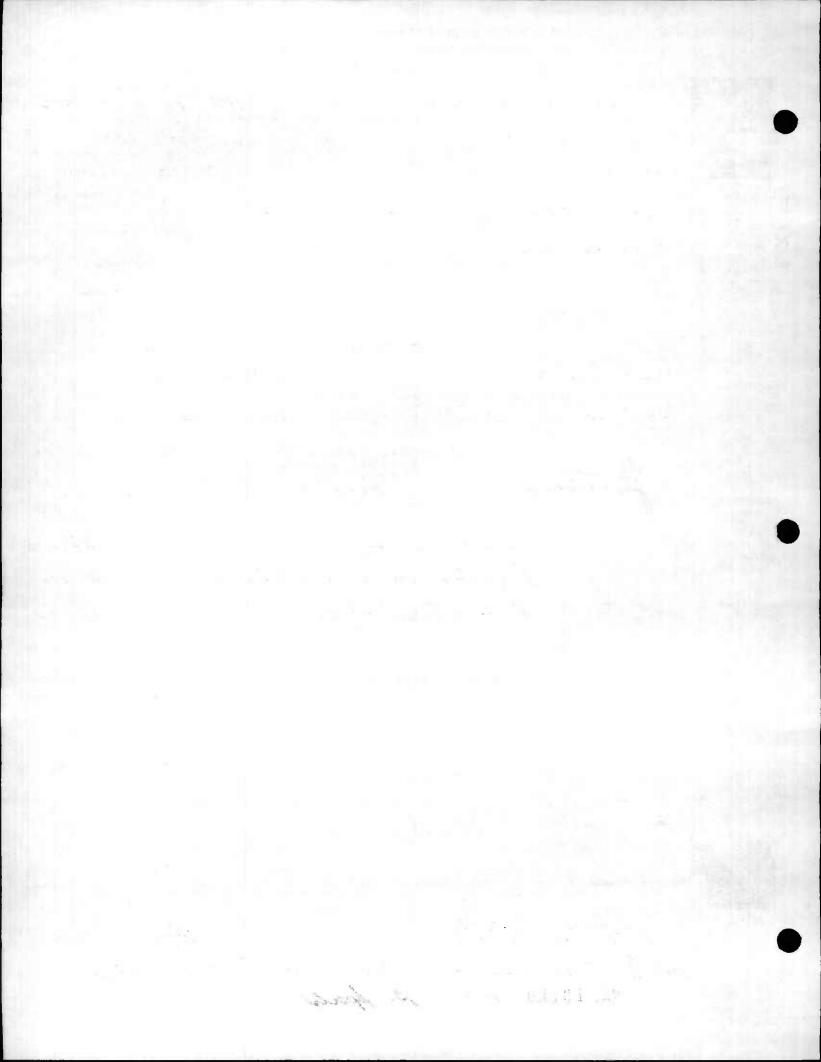


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Elizabeth 0145 Dean 2000 /Medical 4a. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mallard Bay Care Center Cambridge Dorchester If Under 1 Year 5. Social Sacurity Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Days 1□ M XX F Director 214-07-8531 Aug 19, 1905 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or liems 23s or 28s-f show the Medical Examiner must be notified at Maryland Dorchester Cambridge Director XIX Yas 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 517 Governors Avenue Funeral 21613 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2**XX**No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 ☐ Yes 2XX No Spacify: White Completed by Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7 is marked othe traumatic event, 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be and 2 should be saith and Mental Walter H. Price Mary Theresa Shimek ပ 19a. informani's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a to it item 27 is nor other trace Richard Bradshaw 517 Governors Avenue Cambridge, Maryland 21613 20b. Place of Disposition (Nama of cemetery, cremetery or other placa) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, Stale 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 5/19/00 Cambridge, Maryland 21. Signature Mineral Service Licansee 22. Name end Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Sevile Dementin 4nn Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed bunial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury Box 68760. physician that initieted events resulting In death) Last the Dua lo (or as a consequar for use Records, P.O. Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed page 2 should be de by 24b. Were eutopsy tindings available prior to completion of causa of death? Completed 24a. Was an autopsy performed' 1 Yes ZENo 1 ☐ Yes > No of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Shursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA this funeral 27. Menner of Daath . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury st Work? 28d. Describe how Injury occurred After 1 Sitature Division 5 Pending investigation 24 hours after death. Funeral Director: A 1 Yes 2 No 943 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 4 Homicide filled Hospital Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical within 24 hor To the Fune completely fi (Check only one) the th 29b. Signature and title of certified 29c. License number 29d. Dale signed (Month, Day, Year) 30. Neme and agt ted cause of deeth (Item 23a) (Type, Print) Mes CO//ITT 302

32. Registrar's Signature

State Registr<u>ar</u> 31. Date filed (Month



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 15, **Physician** Lois Downey 2000 0020 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Sept. 27, 1935 Birthplece (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 20XF Director 060-30-0548 64 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or frams 23a or 28&-f ahon any Injury or other traumetic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1520 Ridout Lane 21401 United States Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ■ Never Married 2 → Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Theret T. Taylor Evalyn Ridout 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Downey 1520 Ridout Lane Annapolis, Maryland 21401 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Whitehall Cemetery 05-18-00 Annapolis, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** fmmediate Cause (Final disease or condition resulting In deeth) /Medical ACUTE MYOCARDIAL INFARCTION Examiner Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enler Underlying Ceuse (Diseese or injury that Initiated events resulting in death) Last and Due to (or es a consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by page 2 should be detact 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings evailable prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? 1 Yes 2 🗆 No 1 Yes 2 10 certificate Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely lilled in by the funeral di 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 DNetural 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifie edical (Check only one) \$ 29b. Signature and title of contified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item-23a) 1/6/0 31. Date filed (Month, Day, Year)

MAY 1 9 2000 Registrar's Signeture State Registrar

DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Day **Physician** William Phillip Doepkens May 14 2000 5:00 AM /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2657 Davidsonville Rd. Gambrills Anne Arundel If Under 1 Year If Under 24 Hra.
Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) May 11, 1916 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Months Days Country Mary Land Yrs. 84 Director 218-12-9510 Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits worle ! item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yea 2 ☑ No Director Md Anne Arundel Gambrills 10e Street and Number 10f Zin Code 10g Citizen of What Country? 2657 Davidsonville Rd. 21054 USA death y Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ XNo Specify: þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Family Farm 12 pemit. Pages 1 and 2 should be fits Department of Health and Mental Hy important: if item 27 is marked other ency injury or other traumatic avanta 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Doepkens Elisabeth Moritz P 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Marjorie J. Doepkens / wife 2657 Davidsonville Rd. Gambrills, MD 21054 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 5-17-00 Annapolis, MD. 21. Signature of Funeral Service Licansee 22. Name and Address of FacilityJohn M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate tnterval Between Onset and Death Physician /Medical Immediate Cause (Finat piration disease or condition resulting in death) Examiner Examiner siclan and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of) physician a s the burial-Box 68760 certificata be Physician/Medical Due to (or as a consequence of): 88 use jo signed by the a Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 4 Unknown 1 Yes 2 No 3 Probably þ 24a. Was an autopsy parformed? 24b. Were autopsy findings available prior to Completed peen completion of cause of death? page 2 certificate has 2000 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medicat examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yea 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After Neturel 5 Pending Investigation or Attending efter death. I Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital o To the Hospital within 24 hours of To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner ea stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner atated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22028 00 30. Name and address of parson who completed cause of death (Item 23a) (Typa, Print) Suite 1 Crofton, MD 21114 1667 Crofton Center Paul S. Rhodes, M.D. 31. Date filed (Month, Day, Year) MAY 1 7 2000 32. Begistrar's Signeture State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** May 14, James Dunn 2:10 AM 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5116 Holly Drive West River Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Deys Hours Min. Dec. 18, 1 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplece (State or Foreign Country) 1943 New Hampshire **Funeral** Months XXM 2 F Yrs. 56 Director 220-40-7004 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at West River 1 ☐ Yes 2 No Anne Arundel Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5116 Holly Drive 20778 USA Funeral 12. Wes Decedant Ever in U.S. Armed Forces? 1 □Yes 2 □ No If Yes, Give Yeer or Detes: 1966-72 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ◯XNo Specify: Specify: White λq 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 3 yrs. permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 Is marked other th any Injury or other traumatic event, the once. Owner Hospitality 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Margaret M. O'Connor Beverly W. Dunn 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5116 Holly Drive West River, Maryland 20778 Barbara D. Dunn/ Wife 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Metropolitan Crematory 5-16-00 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatural of Funerel Sarvice Licensee 22. Nama and Addrass of Fecility George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd., Edgewater, ules MD 21037 23a. Pert1. Effer the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one ceuse on each line. Approximete Interval Between Onset end Death **Physician** LIVER metastases

Due to (or es a consequence of):

NYENOWN Primary CANCER Immediate Cause (Final disease or condition resulting In death) /Medical wo Examiner Physician/Medical Examiner attending physician and for use as the bune-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Box 68760, The law requires that the death certificate be Dua to (or es a consequença of) P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ģ cate has been significant category. 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en autopsy 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Division of Vital al or Attending Physician: The safter death.

I Director: After this certificate of in by the funaral director, pa 25. Was case refarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2X No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1XXIIotural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medical 29e. Certifier VEXcertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and menner steted. 20b. Signature and afte of certifier 29c. License number 29d. Date signed (Month, Dey, Year) DC 21359 May 15, 2000

State Registrar

MAY 1 6 2000

Naiyer A. Rizvi, M.D.

31. Date filed (Month, Dey, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

3800 Reservoir Rd., NW Washington, D.C. 20007 32. Registrar's Signetura

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Elsie May Duvall May 2000 5:05 PM 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Continuum Care Sykesville Carroll If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) 7. Age (In yrs. lest birthday) Months Deys Hours 1□M 2⊠F Yrs. 219-05-2748 85 Sept. 26 1914 Maryland Usuei Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TNo Maryland Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 7309 2nd Ave. United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 7th Liquor Store Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Unknown Burdette Claire Wetzel 19a. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Carl Duvall Son 1505 Rosemont Ave. Frederick, MD 21702 20b. Place of Disposition (Name of cometery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State May 10 2000 Mt. Airy, MD

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, important: if them 27 is marked other than any injury or other 4 ☐ Donetion 5 ☐ Other (Specify) Marvin Chapel Cemetery 21. Signature & Funerei Service Licensee 22. Name end Address of Fecility Burrier-Queen Funeral Directors, P.A. 0 1212 W. Old Liberty Road Winfield, MD 23a. P.011. En or the disease, or complications that causedity death. Do not enter the mode of dying, such as cardiac or respiratory errest, been feilure. List only one cause on each line. **Physician**

21784

Immediate Ceuse (Final disease or condition resulting in death)

Approximete Intervel Between Onset end Deeth

Physician

/Medical

Examiner

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Funeral

Director

7 is marked other than "natural, or itsms 23a or 28a-f show traumetic event, the Medical Examiner must be notified at

/Medical Examiner

attending physician and for usa as the buriel-transit

8

page 2 has

filled in by the funeral

certificate

Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifics

To the Hosp within 24 hor To the Fune completely fi

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

by

Completed

Be

10

Certification:

Medical

Baltimore, Maryland 21215-0020

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

Due to (or es e consequenca of):

Due to (or es e consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy

24b. Were autopsy findings eveileble prior to completion of cause of deeth?

1 ☐ Yes 200 No

26. Plece of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

20.	AAGS	case	rererred	to	megica
	exem	iner?	-		
	101	/es	2 No.		

27. Menner of Deeth

28e. Dete of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28b. Time of

28c. injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Neturel 2 Accident 3 Sulcide 4 Homicide

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier

Tertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner as stated.

Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated.

29b. Signeture and title of cartifier

-m

29c. License number

29d. Date signed (Month, Dey, Year)

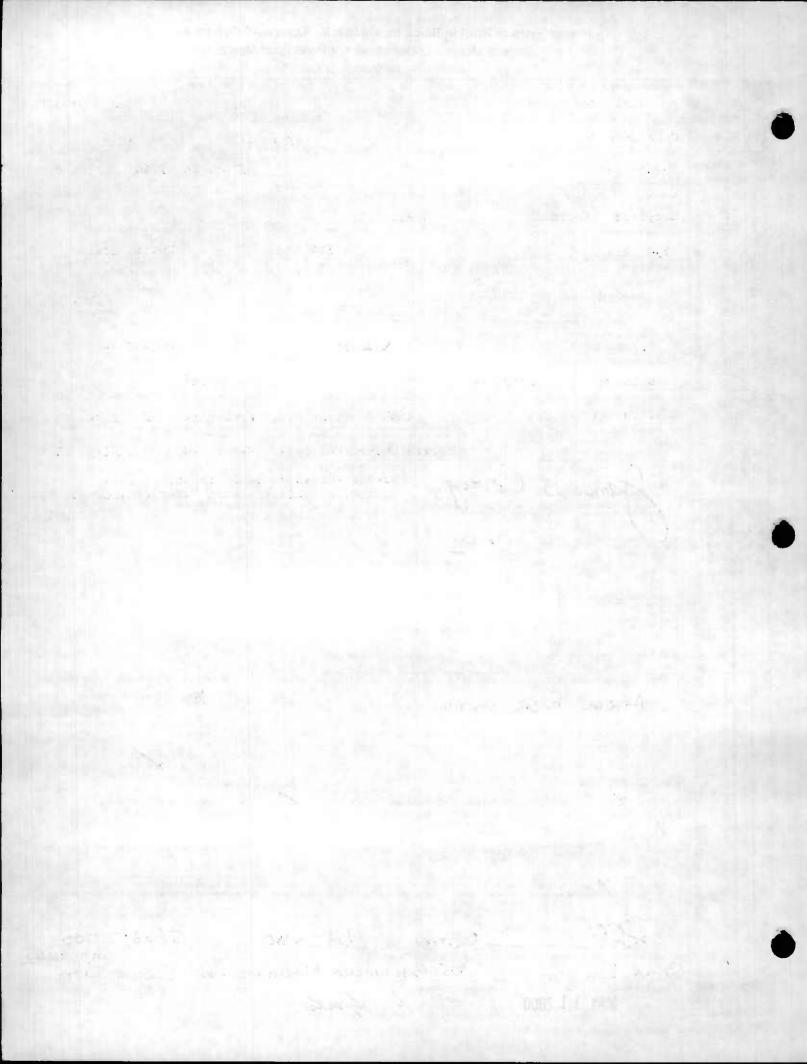
30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 9051 BALTIMORE NATIONAL PIKE.

SHELKAT m. 0 31. Dete filed (Month, Dey, Yeer)

MAY 11 2000

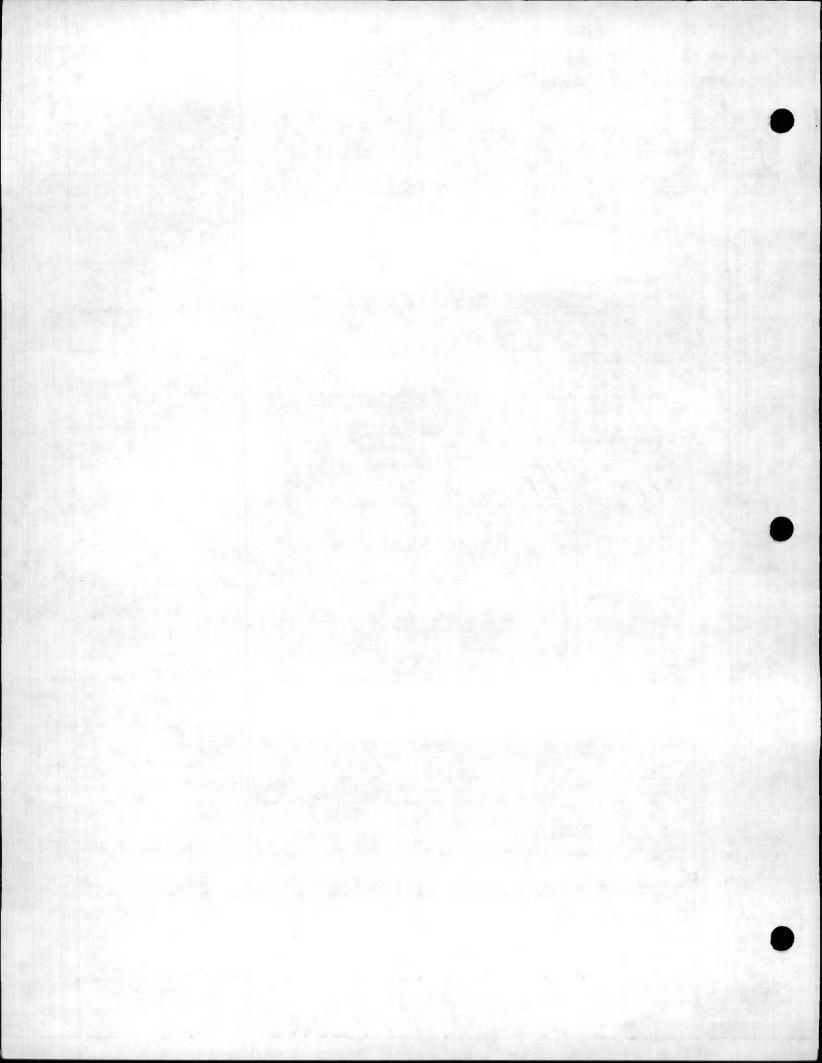
32. Registrer's Signeture

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ector	101-10- Usuel Residence		12XM 2□F	90	Yrs.	Months De	ys Hours	March	Birth (Page) 10	New York
9	10a. Stete	10b. County			y, Town or L	ocation				10d. Inside Cit
rai Director	MD	Prince	George	Lau	ırel					1 ☐ Yes
Dire	10e. Street and					10f. Zip Cod			10g. Citizen of V	What Country?
era	9000 Bri	iarcroft I	12. Was Deceder	at Ever in III	C 12	2070		7 (Specify Vener	USA No. 14 Page	e - American Indien,
Examiner must by Funeral	1 Never M	lerried 2 Married d 4 Divorced	Armed Forces	s?] No	3. 13.	If Yes, specify C		? (Specify Yes or uerto Rican, etc.)		ck, White, etc. White
leted by		15. Decedant's I	Education		16e. Deci	edant's Usual Oc	cupation		16b. Kind of Bu	usiness/Industry
event, the Medical Be Completed	Elemantary/Se	econdery (0-12)	rade completed) College (1-4o	r 5+)	(Give	e kind of work do DO NOT use re	ne during most of tired)	working		
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cian	23a. Part / Enil shock, or h	er the disease, or con naart failure. List only	implications that cause in one cause on each	ed the death lina.	n. Do not er					Approximate Intervel Baty Onsat and D
dical	Immediale Caus diseesa or cond	se (Finel		ed the death lina.						Approximate Intervel Baty
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pletaly filled in by the funeral director, page 2 should be detached for use as the burial-transit and pletaly filled in by the funeral director. To Be Completed by Physician/Medical Examiner	Immediate Caudiseesa or cond resulting in deet Sequentially list if any, leeding it cause. Enter Ur Causa (Disease their initiated ever resulting in deat Part II. Other sig 25. Wes case reexaminer? 1 Yas 2 27. Menner of Do Natural 2 Acciden 3 Suicide 4 Homicid 29e. Certiflar (Check only one)	se (Finel littion th) conditions, o immediate noderlying or injury ants the conditions of the conditi	a. PVLA c. D1A d. Contributing to death Contributing to death	Due to (or Due to (or Due to (or but not rasu tient 2 tient 2 tient jury lay Year) njury - At house of examinati	reseconse RY reseconse C Htt as a conse ulting in the ER/Outpatie 28b. Tima a Injury wiedge, dee	equence of): EDEM (equence of): CART quence of): underlying ceuse and 3DOA of 28c. I M 28c. I M 29c. Lic	given in Pert I. 26. Place of Other: 4 \(\text{Nursir} \) Nursir \(\text{Nursir} \) Vork? \(\text{Yes} \) 2 \(\text{No} \) No ce	23b. Di 24a. W pe 1[Death (Check online Home 5 Re 28d. Describ 28f. Location City or 1	id tobacco use country of the how injury occurs of the how injury occur	Approximate intervel Baty Onsat and D S M I N I N I N I N I N I N I N I N I N I



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARIE **Physician** 02:30AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Disath 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Sociel Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Aug. 27, 1911 Birthplece (State or Foreign Country) **Funeral** 10 M XXF Deys Months Hours 88 171-16-7956 Alabama Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Howard Columbia 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 8498 Greystone Lane 21045 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXX No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) or Barra 14. Race - American Indien, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ☐ Never Merried 2☐ Married 1 ☐ Yes ZH No Specify: Baltimore, Maryland 21215-0020 Black PV Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) Supervisor State of Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Department of Health and Mental Important: If Item 27 is marked of Joseph Banks Carrie Drakeford 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Intorment's Name/Relationship (Type, Print) Thelma Davis/Daughter-in-Law 8498 Greystone Lane, Columbia, MD 21045 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, Stete 1X Buriei 2 ☐ Cremetion 3 ☐ Removei trom State Arbutus Memorial Cemetery 5/16/ Arbutus, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee M00741 5555 Twin Knolls Road, Columbia, MD 21045 demmer 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) /Medical **Examiner** Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Que to (or as e consequence of) Box 68760. Due to (or as e consequence of) r use as t P.O. Part II. Other significant conditions contributing to deeth,but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 24b. Were eutopsy findings evailable prior to completion of cause of deeth? after death.

Director: After this certificate has been sign of the funeral director, page 2 should it 24e. Wes en eutopsy performed? TIA 2 00 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 25. Was cese reterred to medice! 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo Medical Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

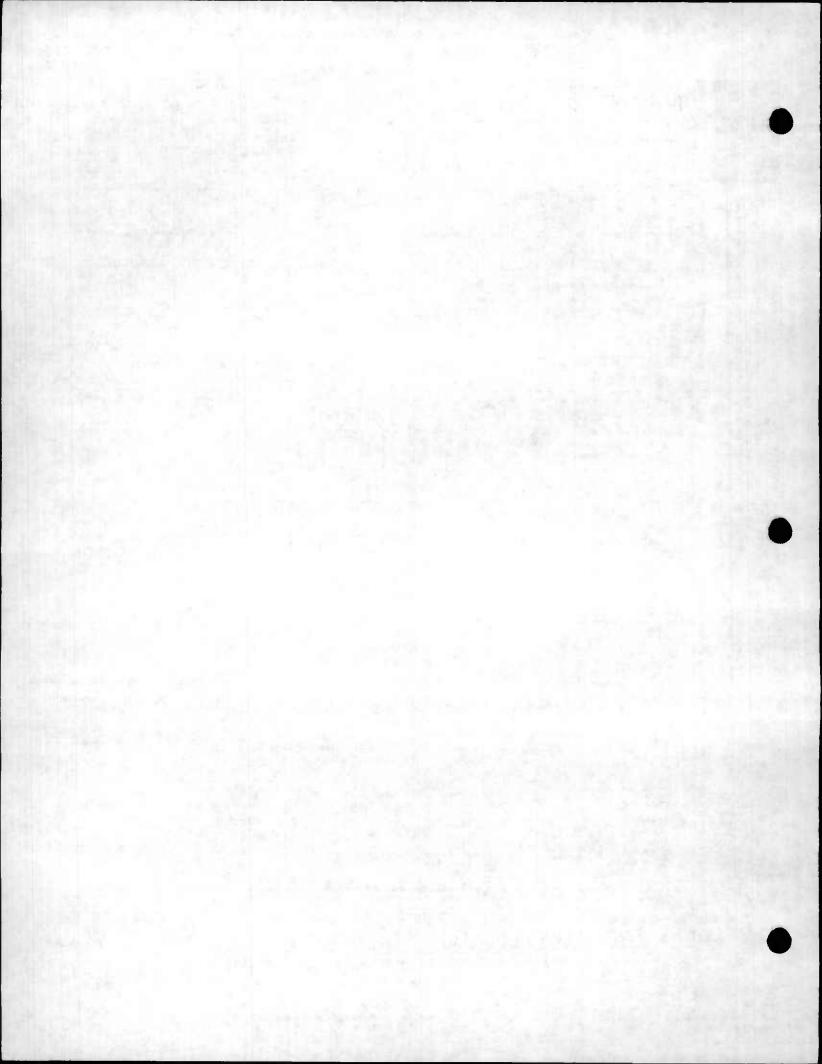
State

Registrar

31. Date filed (Month, Day, Year)

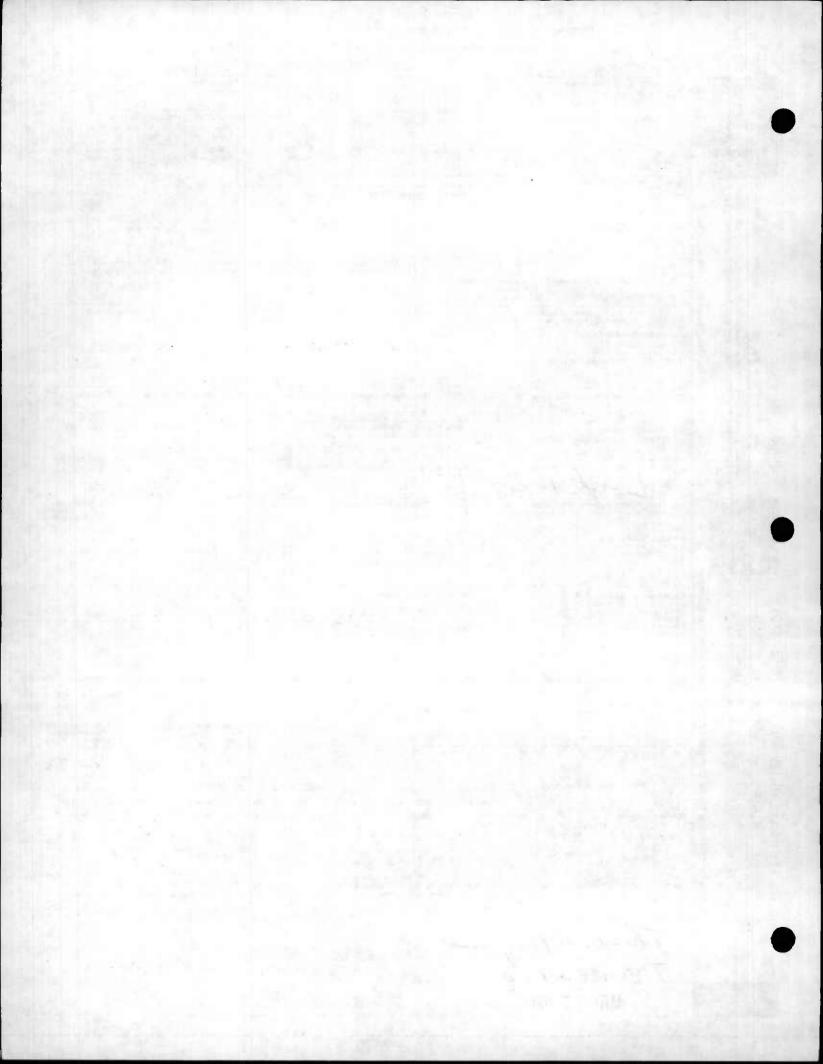
16

32. Registrer's Signeture



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

U	NKNOWN 00	-118 JOHN F. DOUGI	State of Marylan		rtment of H			giene leg. No.	17272		
п	Physician	1. Decedent's Neme (First, Middle, Last					2. Date of Dea Month	th Dey Ye	3. Time of Death		
	Physician /Medical	John F. Douglas	5					5, 2000	0107 AM		
	Examiner	4e Facility Neme (If not institution, give					Location of Death	4c. County of C	Death		
		MARSHALL CORNER	ROAD			POMFRE		CHARL			
	Funeral Director	5. Social Security Number 6. Se 219–94–7401	x	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min	. (Month, Day	Year) 9. r 13,1977	Birthplaca (State or Foreign Country) Maryland		
	B B m	10a. Stete 10b. County	10c. Cit	y, Town or Loca	ation		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits		
	Maryta of show fled at tor	Maryland Prince Ge	orge	Camp	Spring	C			1⊠ Yes 2 No		
	oth with the Maryland 23a or 28a-f show wat be notified at ral Director	10e. Street and Number	orges_	Camp	10f. Zip Code	5		10g. Citizen of What Country?			
	23a o at ba	6336 Maxwell Dr.	Apt.3		20746			USA			
Maryland 21215-0020	hours after death v hurst, or heres 23 at Examiner must at by Funeral	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		as Decedent of H Yes, specify Cub	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - / Black, V Specify: B	American Indian, Vhite, etc. lack		
9	72 hor matura dical E	15. Decedent's Edu		16a. Decede	nt's Usual Occup	ation		16b. Kind of Business/Industry			
215	ed within 72 ho ygiene. er then "natur t, the Medical. Completed	(Specify only highest grad Elementery/Secondery (0-12)	le completed) College (1-4or 5+)	(Give ki	ind of work done O NOT use retired	during most of wo	orking				
21	dwill plane the the	12	College (1-of 5+)	Floor	Techni	cian		Manor Nur	sing Home		
P	tal Hy d other event.	17. Fether's Neme (First, Middle, Last)				18. Mother's Na	me (First, Middle,				
la la	Menta Menta arked arke a	Jelius Jackson		Agnes	Johnson						
ar	one and a	19e. Informent's Neme/Relationship (T)	rpe, Print)	19b. Mailing	Address (Street	and Number or F	lural Route Numbe	r, City or Town, Ste	te, Zip Code)		
	and saith	James and Agnes Joh	nson-parents	6336 N	Maxwell 1	Dr. Camp	Springs	Maryland	20746		
or o	of Hear	20e. Method of Disposition	20b. P	Plece of Disposi	tion (Name of story or other plea		Dete	20c. Location - City	or Town, Stete		
Ĕ	Pages nent of my or o	14 Burlel 2 □ Cremetion 3 □ F 4 □ Donation 5 □ Other (Specify)	temovel from State		1 Garde		/00	Clinton, M	arvland		
Baltimore,	ponte y inju	21. Signeture of Funeral Service Licens	ee , MM	a 22.	Neme and Addre	ss of Fecility		- 4	-A		
æ	SOLES	I Donald h	CALL	700	me There		D 3 3		1 1 00000		
		23e. Pert1. Enter the diversity, or compleshock, or heert factors. List only or	ications thet caused the deat	h. Do not enter	the mode of dvir	ral Home	P.A. AQI	lasco, Mar	yland 20608		
	Physician /Medical Examiner Examiner Examiner	Immediete Ceuse (Finel disease or condition resulting in deeth)	Multip	t la	Turly ence of):				Onset and Death		
	and and H-trar	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	Due to (o	or as e conseque	ence of):						
8760,	physician and physician and sthe burial-transit	Cause (Diseese or injury	o								
9	生 O 6 二	that initieted events resulting in death) Last	Due to (or	r as a conseque	ence of):			4-18			
Box	death e atter ed for u						1				
a	that the death certific led by the attending p detached for use as y Physician/Mee	Pert II. Other significant conditions cor	ntributing to death but not resu	en in Pert I.	23b. Did tobacco use contribute to the cause of						
Vital Records,	The lew requires that the death centrate has been signed by the attending page 2 should be detached for use Completed by Physician/N				24a. Wes a perfor		4b. Were autopsy findings eveilable prior to completion of cause of death?				
Re	The lew ate has t page 2 s						λ.	• • • • • • • • • • • • • • • • • • • •	/		
क	ysician: The I s certificate he director, page	25. Wes case referred to medical						es 2 No	1 Yes 2 No		
5	Physician: this certific ral director, TO Be	examiner?	lospitel:	EDID A COLUM	oCI DOA Oth	or	eth (Check only or		a v. AEL COTTATE		
		27. Menner of Death	1 Inpatient 2 2	ER/Outpatient 28b. Time of			Home 5 ☐ Resid	ence KXOther (Specify) AT SCENE		
5	After fune	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	28c. Injur Wor	Yes 2 No	Frehich	in dul	and occup		
Division	tal or Attending P rs after death. al Director: After t led in by the funer: Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Plece of Injury - At he	115 H	R	A	28f, Location /S	treet end Number o	r Rural Route Number,		
S	or Direction	4 ☐ Homicide determined	building, etc. (Specify	(Y)	n, routory, ooo		City or Tow	n, Stete) Mar.			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1☐ Certifying Phys	sician: To the best of my know	wierine death o	occurred at the tir	ne date and plac	men men		hartin charles and		
	he Hospi in 24 hou he Funer pletely fill edical		ner: On the basis of examinat end menner steted.	tion end/or inve	stigation, in my o	pinion, deeth occ	urred et the time, o	late end plece, and	due to the cause(s)		
	within To the comple	29b. Signeture end title of certifier	1.		29c. Licens	e number		9d. Date signed (A	fonth, Day, Year)		
	- 5 - 0	17/1/1	1.1		0.0	C.M.E		MAY 15,	2000		
		30 Name and addition of the May	There	020) (7: 2	/anix						
		30. Name and address of person who co				Baltim	ore Mars	land 2120	11		
	State	31. Date filed (Month, Dey, Year)	22. Registrar's Signa		PULLULI	- LALL CHIE	ore, Plary	-CIRCI 212(/ 1		
	State Registrar	MAY 17 20	100 Departe	19.	Loon	21					



Please Type or Print in Black indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item #7, 5/17/2000, WCHD, E.T. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year **Physician** 9, 2103 GRACIE M. DICKERSON 2000 MAU /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (if not institution, give street and number) Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Months Days Hours Mir. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M ZXIF Days 76-77 Vrs. 229-36-2512 Director 02/19/24 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d: Inside City Limits IXI Yes 2 No Director 288-1 Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 234 Deers Head Center USA 21801 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes ZX No If Yes, Give Year or Dates: 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 Widowed 4 Di Divorced Black. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 6th permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name /First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Strand Lizzie White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) Lincelbell Downing/Daughter P. O. Box 185, Mappsville, VA 23407 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State t ⊠Burial 2 □ Cremation 3 □ Removal fro Household of Ruth Cem. 5/13/00 Accomac, VA 4 □ Donation 5 □ Other /Shecily) 21 Signature of Funeral Service Lice 22. Name and Address of Facility Cooper & Humbles Funeral Co., Inc. p. 0. Box 176, Accomac, VA 23301 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) LITOSEDSIS /Medical Examiner Due to (or as a consequence of): ichetes mell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): ASCO. 68760. physician s the buria Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one)

Vital to

2512

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DICKERSON

SPACIE

death.

this certificate Altar Division after deatl Director: 6 Hospital 24 hours a e Funeral within 2 To the I å

Certification: To

Medical

State

Registrar

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

1 Yes 2 No

27. Manner of Death

1 DiNatural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

28a. Date of injury (Month, Day Year)

29c. License number D0054127

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28I. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

De mar

28d. Describe how injury occurred

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) 13156

Alon DAVIS MO 31. Data filed (Month, Day, Year)

MAY 1 7 2000

32. Registrar's Signature comer

Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26b. Time of

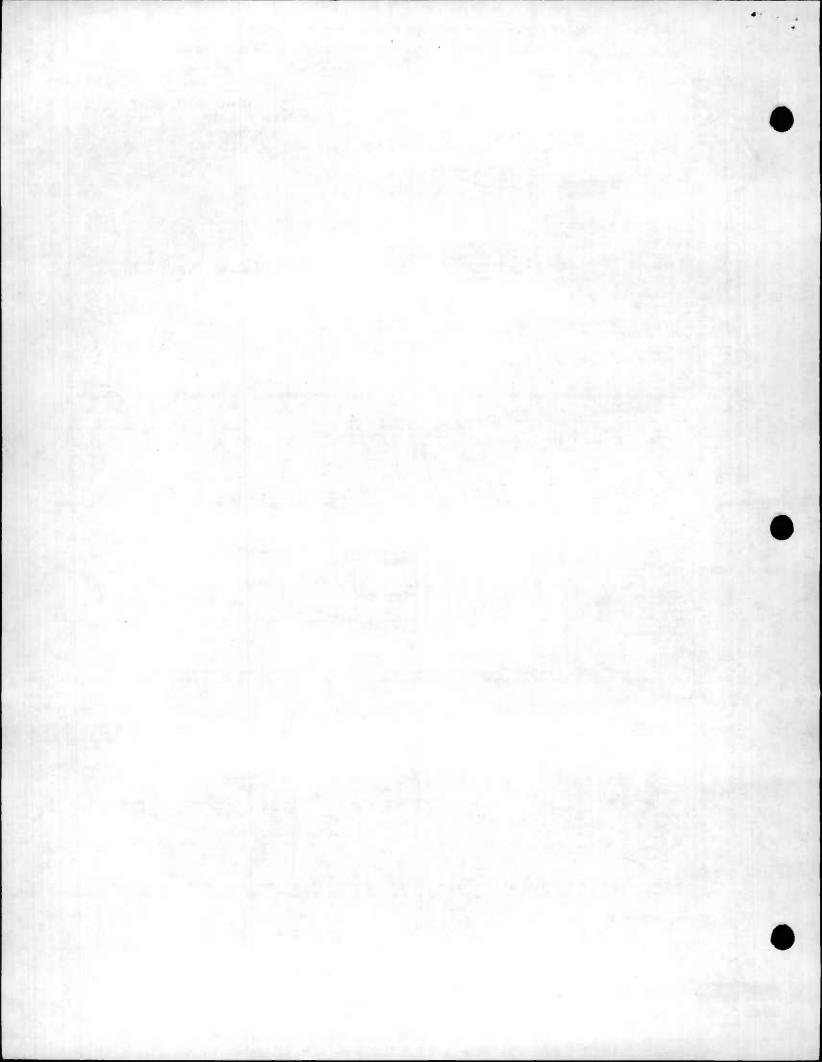
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

oacks

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Data of Death 3. Tima of Deeth Month Physician Year 1:20 PM Constance Cunsolo Davis May 13,2000 /Medical 4a Facility Neme (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec.1,1909 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2₺F 101-22-6254 Yrs 90 Director Italy Usual Rasidence of Decedent pemit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Departmant of Health and Mentel thyslene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show enty injury or other traumstic event, the Medical Examinating the notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director Montgomery Potomac 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11215 Seven Locks Road 20854 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Giva Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14 Rece - American Indian Bleck, White, etc. 1 ☐ Nevar Merried 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: à 3 ☐Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Alban Beauty Salon Beauty Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Joseph Cunsolo 0 Maria Rose Gulizla 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Rose Partenope / niece 101 Schooner Lane, Jupiter, Fla. 33477-4034 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete May 18. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Washington, D.C. 22. Name end Address of Facility
DeVol Funeral Home 21. Signeture of Funaral Sarvice Licensee 2222 Wisconsin Ave., N.W., Washington, DC 20007 23a. Peril Errar the disease, or complications that caused the death. Do not enfar the mode of dying, such as cardiec or respiretory arrest, short or heart feiture. List only one cause on each line. Approximate Intervet Batween Onset end Death **Physician** Immediete Cause (Finet disease or condition rasulting in deeth) /Medical Cerebrovascular accident 48 hours Examiner Dua to (or as a consequence of): Examiner Uncontrolled hypertension attending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by the 1 Yss 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: director, 8 25. Was case referred to medical 26. Place of Death (Check only ona) Hospifal: 1 Hnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To this After this funeral of 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury st Work? 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and piace, and dua to tha cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and manner steted. 29e. Certifier

To the Hospital or Attending within 24 hours after death.
To the Funerel Director: After completely filled in by the funerel of the function of the funerel of the funerel

29b. Signature and title of certifiar 29c. License number 29d. Defe signed (Month, Day, Year) D-27660 panal moun 00

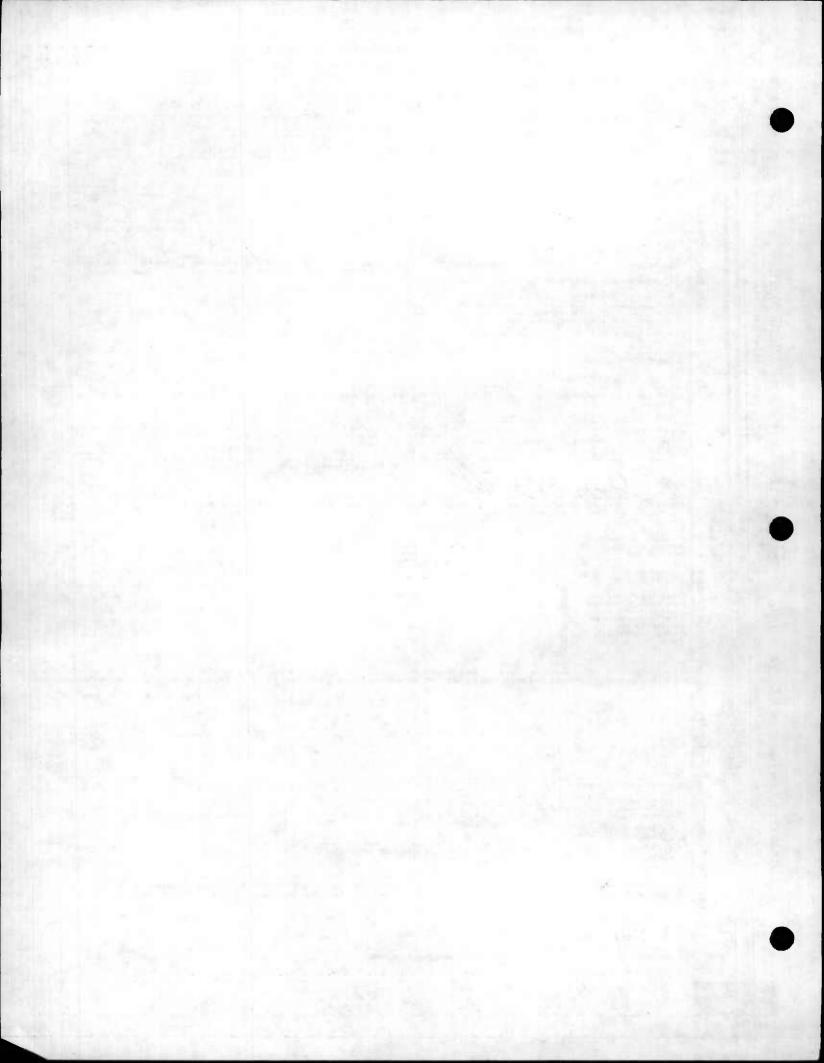
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alpana Goswali, M.D., 10901 Connecticut Ave., Kensington, Md. 20895

State Registrar (Check only one)

31. Date filed (Month, Day, Year) MAY 1 7 2000

32. Registrar's Signature Benev



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

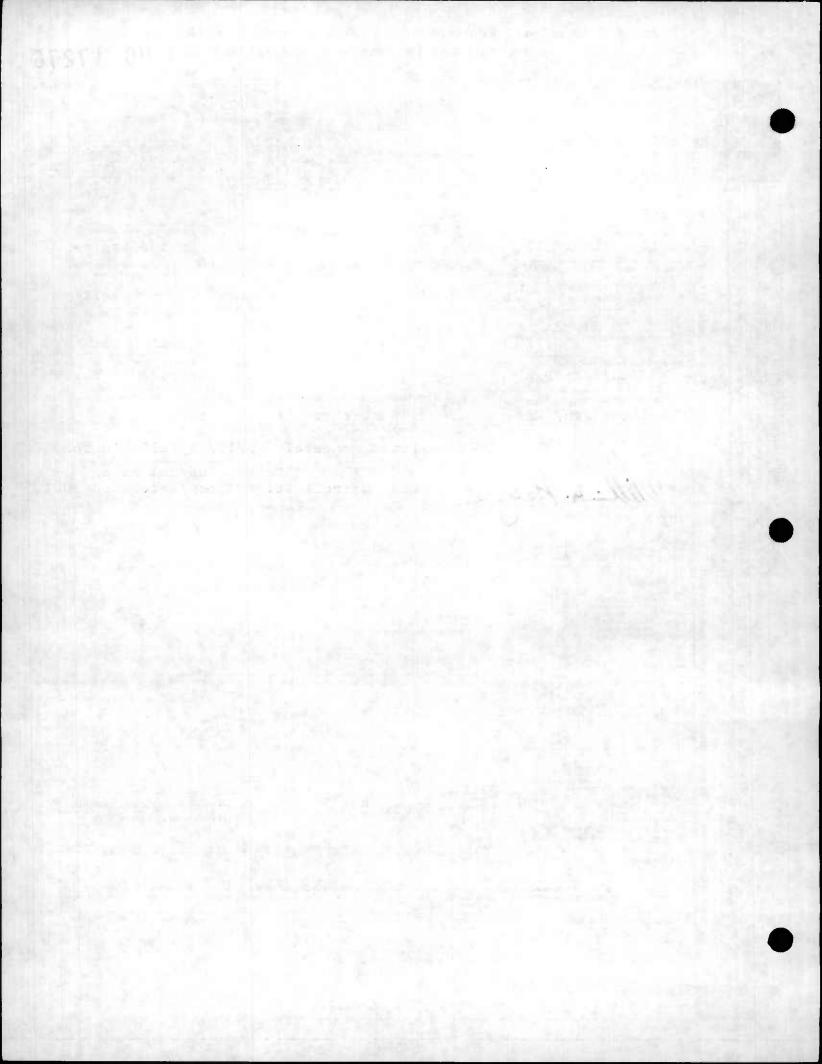
State of Maryland / Department of Health and Mental Hygiene O O

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Funeral Director	5. Social Security Number 137-94-8047 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 28, 1920 U								
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ortan inju	21. Signature of Fuperal Service Uce				brew Me				
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State of Maryland / Department of Health and Mental Hygiene 00 17276

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Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside	City Limits
Maryland Montgomery Bethes					de .		10a. Citizen of	Mhat Cour		5 2 110
10e. Street and Number 6916 Heatherhill Road					36		United			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** MARY EVELYN DODSON 0112 MAY 14 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SLUTPL SPRING MOGREGA HOLY CLOSS HOSPITER 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** 1□ M 2☑ F Yes 577-03-7829 85 Director Apr. 3, 1915 Washington, DC **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 □ Yas 2 No permit. Pages 1 and 2 should be filled within 72 hours after death with the Mi. Department of Health and Montal Hyglene. Important: if from 27 is marked other than "natural", or items 23s or 28s-fi any injury or other traumatic avent, the Medical Exercises must be notified. Director Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 12818 Teaberry Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas: 1 Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-for 5+) 12 Settlements Jerry Walman Builder 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) 8 George Colecchia Elvira Colaizzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Donald Dodson / Son 12206 Hunters Court, Rockville, Maryland 20852 Baltimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 05/17/00 Silver Spring, Maryland 22. Nama and Addrass of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licenses 11800 New Hampshire Avenue Silver Spring, Maryland 23a Part I. Enfor the descent or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) CONCESTIVE HOART FAILURE /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner ADDITIC INSUPPLICIONEY AND STEWOSIS The lew requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): pue Box 68760. physician the th Due to (or as a consequence of) US0 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown INTENTROCHANTERIC FORTURE PLT. HIP Division of Vital Records. à 24b. Were autopsy findings available prior to completion of causa of death? should should Completed 24a. Was an autopsy performed? has 1 ☐ Yes 2 No 1 Yes 2 No certificata Physician: director, 8 25. Was case refarred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) SUPPRO AND FOU 22 HOR GAROW After 1 Natural 2 Accident Attanding 5 Pending 05/08/2000 To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 1 Yas 2 No death. investigation 1430 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 128 1870 86645 (2016) 4 Homicide HOUR MO Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier edical **On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. ann)

State Registrar

DHMH 16 Rev 6/95

MAY 1 7 2000

29b. Signar

and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONL I WALGOUS, M. IIIVS POOKNING

(CARE MANERIE) (CARE

32. Registrar's Signatura

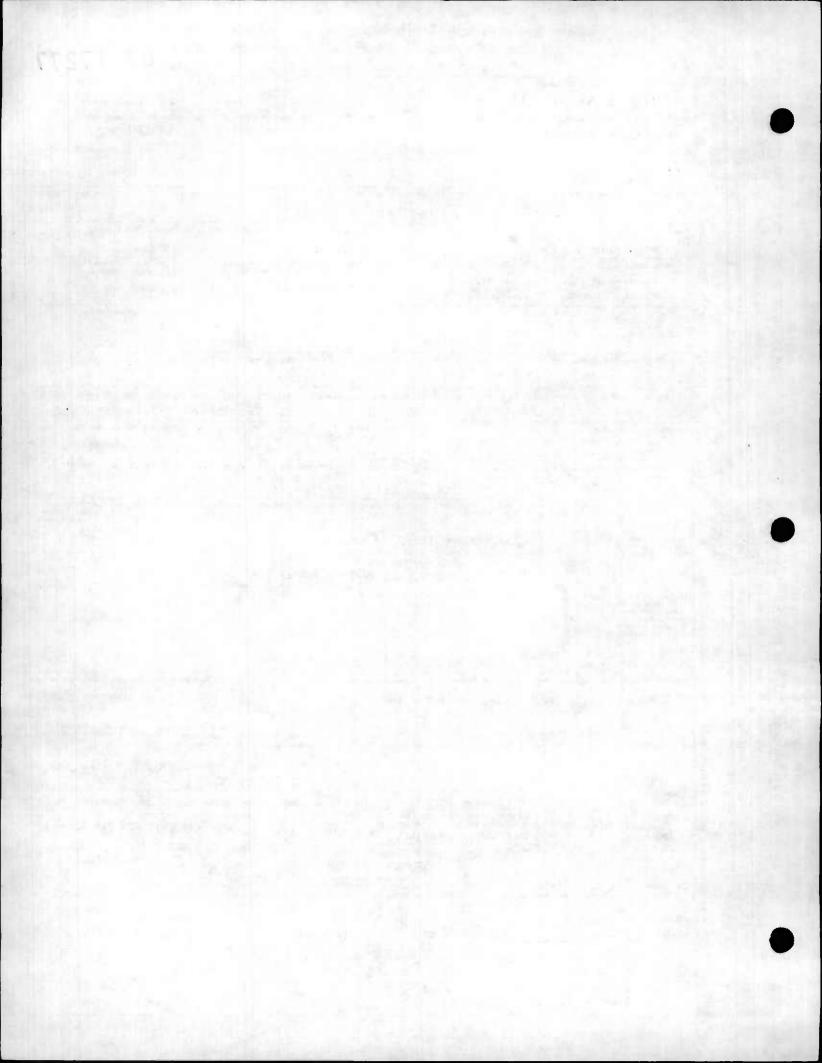
29c. License number

015236

29d. Data signed (Month, Day, Year)

MAY 14, 2000

Ripo, Rogalius, Mo 20852



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dey Month Year **Physician** THOMAS 11:44 P.m. DOHLMANN 05 13 2000 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE HOSPITAL If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** X M 20 F Days 29 Yrs. 254-98-3469 Director August 17,1970 Columbus, Geor Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryfei Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any holivry or other traumatic event, the Madical Executer must be notified at acts. 1 Yes 2 No Director Arlington Virginia Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1108 North Ohio Street 22205 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 XNo If Yes, Give Yeer or Detes: 1 Never Merried 200 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specity: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Development/Private Elementery/Secondery (0-12) College (1-4or 5+) Industry Business Manager 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Dohrmann Lunn Martin 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Sylvia Miller Dohrmann Wife 1108 North Ohio Street Arlington, Virginia 22205 to the of Disposition (Name of Date 20c. Location-City or Town, State 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete Cremation Center 4 Donetion 5 Other (Specify) 5/17/2000 Chantilly, Virginia Signature of Fungual Service Licenses Robert J. Murphy Funeral Home, Inc. 22. Name and Address of Fecility 4510 Wilson Blud. Arl. Va. 22203 Approximete tntervel Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the deaty. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical . ATRIAL FIBRILLATION 5 hours WITH CONGESTIVE HEART GAILURE Examiner Due to (or es a consequence of): Examiner 29 years GREAT YESSELS (OPERATED) CONGENITAL TRANSPOSITION The law requires that the death certificate be executed g physician and as the bunal-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): P.O. I Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed is should be det Records, à 24b. Wera autopsy tindings availabla prior to complation of cause of death? Be Completed 24a. Was an autopsy page 2 1 Yes 2KI No 1 Yes 2 No certificate of Vital To the Hospital or Attending Physician: 25. Was case reterred to medicat 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No this 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Affer Division A hours after dea. 1 SNeturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funerel DI completaly filled in 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. Medical

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State

29b. Signeture end title of cartitier

31. Dete tiled (Month, Dey, Year)

Caulan,

Sandeel

Gautam Mar box 32. Registrer's Signeture

M.D.

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

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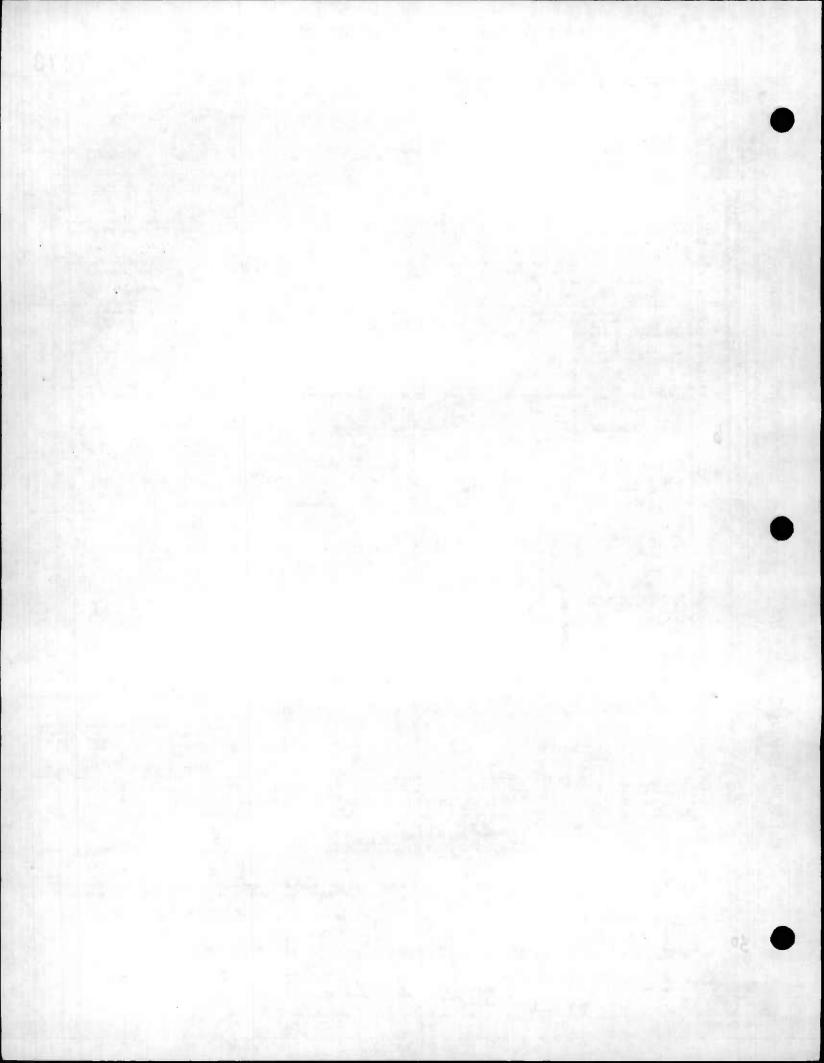
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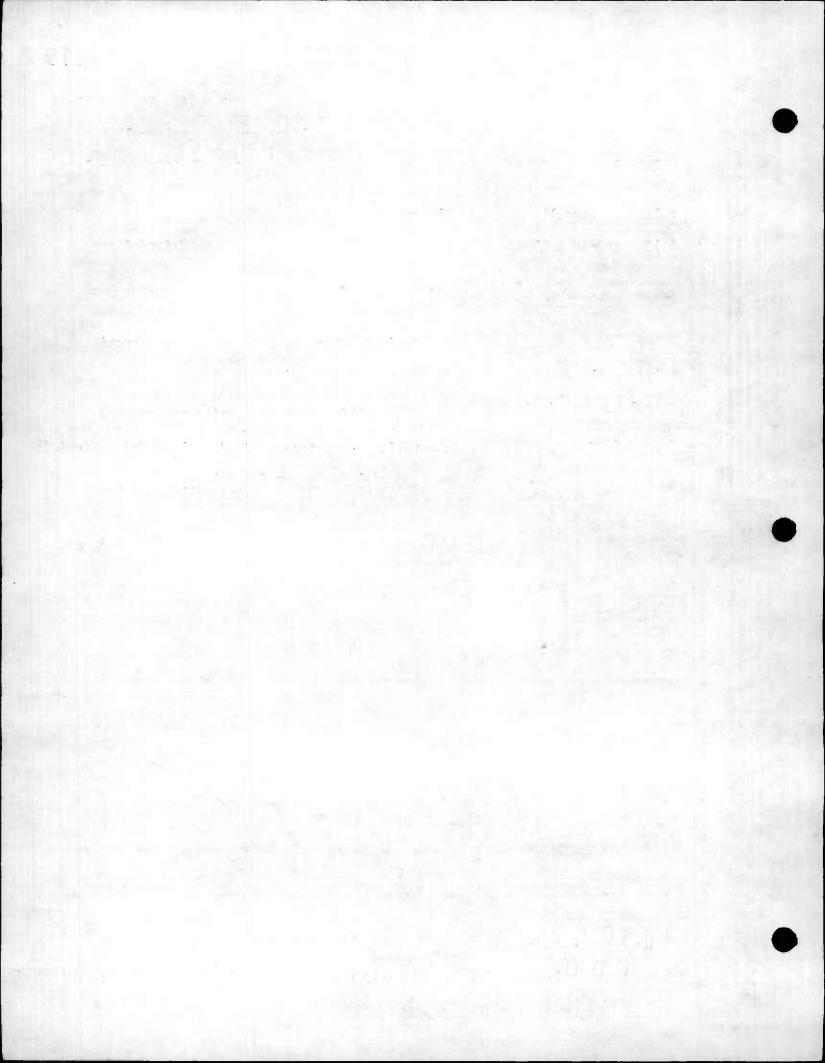


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State of Maryland / Department of Health and Mental Hygiene 00 17070

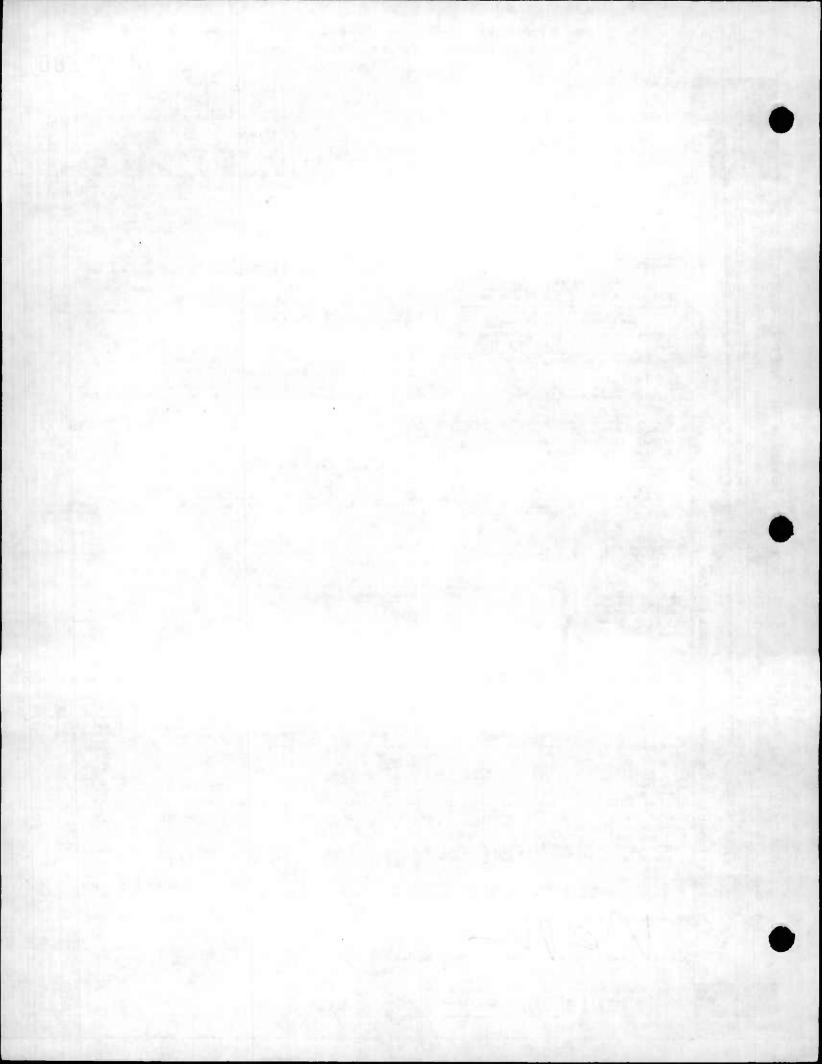
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xaminer	rasulting in death)	Due Due	to (or es e conse	quence of):	:				10-41		
in end tal-transit Examiner		h									
physician end s the burlatransk	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying	Due	to (or as a conse	quence of):	:				-		
lcian burla	Cause (Disease or injury										
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ğ . Z		d							1		
attendi for use	Date Other lands	tributing to death but not resulting in the underlying cause given in Dant I						23b. Did tobacco use contribute to the cause of de			
d by the attend eteched for us Physician/	Pert II. Other significant conditions contributing to death but not resulting in the underlying cau					ing cause given in Pert I. 23b. Did tobacco usa o					
igned to be determined by PI							_ '''	Tala 20190	3 Probably	4 Olik	
should b							24a. Was	an autopsy ormed?	24b. Were aut available	opsy findi prior to on of caus	
page 2 should						- 10 F			of death?		
	or Wi							Yes 2 No	1 ☐ Yes	2□ No	
	25. Was case refarred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospitel:	2 ☐ ER/Outpatie	ent 3 DC	Othe	ner .	Deeth <i>(Check only)</i> g Homa 5 Resi			- 1	
2 -	27. Manner of Death	26a. Date of Injury (Month, Day Ye			28c. Injun			how injury occurre			
a funer	1 ☐Netural 5 ☐ Pending 2 ☐ Accident invastigation		Par) Injury	м		r? Yes 2 □ No	1715	200. Describe now injury occurred			
ris after death. al Director: After t led in by the funer Certification:	3 Suicide 6 Could not be determined	26a. Place of injury -	At home, farm, st	treet, factor	y, office		28f, Location (Street and Number	or or Rural Route	a Number,	
A Die	4 Hourida	28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)									
within 24 hours after deat To the Funeral Director: completaly filled in by the Medical Certifica	29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my niner: On the basis of exa	y knowledge, deel	th occurred	at the tim	e, data and pla	ace, and dua to the	cause(s) and me	nner as stated.	use(s)	
the F	one)	and mannar stated.					oodiioo at alo tillo,				
Within To the comple	29b. Signature and title of certifier	0000			c. License		11	29d. Dala signed			
¥ 68 -	11.41111.1	~(1///			1200	5192	4	May 15	1200	10	
10	- HOV - 1-00	Committee of the Commit									
	30. Nama and addrass of person who Herbert P. H.	completed cause of death	(Item 23a) (Type	, Print)	F 4		Suite 30	201	1.1 1	100	

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Ivialyla	•	rtificate of			Reg. No.	17280	
Physician	1. Decedent's Nama (First, Middla, Last)						eath Day	Year 3. Tima of Death	
/Medical	al Michelle Elizabeth Dunn-Langosch						7, 2000	12:30 ar	
Examiner	4a Facility Name (If not institution, giva street and number) 4b. City, Town,								
	3402 W. Coquelin				Chevy Ch		Montgomery Sirth Pay, Year) 9. Birthplace (Stafa or Figure 1) Country)		
Funeral Director	212-02-5877	02-5877 1□ M 20xF 48 Yrs. Months Days					Hours Min. Sept. 1, 1951		
D a	Usual Residence of Decedent 10a. Stata 10b. County	100 C	City, Town or Lo	postion				10d. Inside City Limi	
a-f sho and sho iffed at	MD Montgome:				1 Tas 2				
terms 23e or 28e-f shown ner.mat be notified at ner.mat be notified at uneral Director	10e. Street and Number 3402 W. Coquelis	20815		10g. Citizan of W Canada					
ar, or	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in the Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:		Was Decedent of If Yas, specify Cu 1☐ Yes 2☑ No	Hispanlc Origin? (S ban, Mexican, Puar o Specify:	pecify Yas or No to Rican, atc.)	0- 14. Race Black Specify:	- Amarican Indian, K, Whita, atc. White	
ted ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Bus	inass/Industry	
within then the Me	(Specify only highest grad	College (1-4or 5+)	- (Giva lifa. Teac		ind of work done during most of working O NOT use retired)			ion	
	17. Father's Nama (First, Middle, Last)	Ji Teacher			18. Mothar's Nar	na (First Middla	, Maidan Sumama		
and be a send of the send of t		unn			E 475 YEAR TO SEE THE SECTION OF THE	zia Mar			
and Mentile market	19a. Informant's Name/Relationship (T		19b. Maili	ng Addrass (Stree	et and Number or Ri			Stata, Zip Code)	
fand 2 feath a m 27 te	Paul R. Langosch -				quelin Terr., Chevy		y Chase, MD 2081		
Pages 1 as nent of Has net if Ham nry or other	20a. Mathod of Disposition 1 Burial 2 Cremation 3 I	nemoval from Stata	· ·	esition (Nama of matory or other pl		Data /18/00	20c. Location - C Beltsvil	City or Town, Stata	
ritine in the party of the part	4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Ligens		Chesapeake Crematory						
Depa Impo Impo	Soft	litt			ral and C Avenue, S				
	23a Part Enter the disease, or comp shock, or heart failure. List only o	ications that caused the dea	ath. Do not en	tar the moda of dy	ring, such as cardia	or raspiratory a	ırrast,	Approximata Intervel Between	
Physician /Medical	Immediate Causa (Final		Cancer					Onset and Death	
Examiner	diseasa or condition rasulting in death)								
<u> </u>		Dua to ((or as a consec	quence or):					
and al-transit	Sequentially list conditiona, if any, leading to immediata	Due to ((or as a consec	quence of):					
sertificate be executed ding physician and se as the burial-transit	Sequentially list conditiona, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last	c. Dua fo (or as a consec	uance of):					
death ce			sulting in the u	22b Did	23b. Did tobacco use contribute to the cause of de				
signed by the attending be detached by the attending be detached for use detached by Physician/N	Part II. Other algnificant conditions co	itributing to death but not ra	sutting in the u	noenying causa g	Iven in Part I.	1 Yea 2 No 3 Pr			
been shoul					performed? 8			24b. Wara autopsy findings available prior to completion of cause of death?	
ystclan: The laving certificate has director, page 2						10	Yas 2 No	1 ☐ Yes 2 No	
or, p	25. Was casa rafarred to medical				26. Placa of De				
Physician: this certific ral director, TO Be (axaminer?	Hospital:	☐ ER/Outpatier	3 7 704 0	thor		idenca 6 □Othe	(Canciba)	
After this funeral di	27. Manner of Death 1 🖾 Natural 5 🗆 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Inj		,	how injury occurre		
To the Heapital or Attending Phy within 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral. Medical Certification: 7	2 Accident invastigation 3 Suicide 6 Could not be 4 Homicide detarmined	28a. Place of Injury - At h building, atc. (Speci	homa, farm, str ify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)			
he Hoepital in 24 hours he Funeral pletely filled edical Co	29a. Cartifier 1 Certifying Phy. (Check only 2 Medical Exami	sician: To the best of my kn- ner: On the basis of axamin and mannar stated.	owledge, deetl ation and/or in	n occurred et the vestigation, in my	tima, data and place opinion, deeth occu	a, and dua to the arred at the time,	cause(s) end mer date and placa, a	nnar as stated. nd due to the cause(s)	
within 2 To the comple	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed	(Month, Day, Year)	
	11/1/1/	111-			1359		May 17,		
12	30. Nama and address of person who or	empleted causa of death (Ite	m 23a) (Type,	Print)		DC (
	Niyer A. Rizvi, MD	3800 Reser	voir Ro	ad NW Wa	asnington	, DC	20007-219	1	
State Registrar	31. Data filed (Month, Day, Year) MAY 1 9 20	32. Registrar's Sign	nature 4	Spork	61				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2000 May 12, **Physician** Eaton 1:44 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Southern Maryland Hospital Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 21, 1925 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 M 2 TF 231-20-0370 74 Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD Prince George Upper Marlboro 1 ☐ Yes 2 ☐ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ģ 6318 Chew Road 20772 USA or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mentel Hygiene. Important: If them 27 is marked other than "natural", or frem any Injury or other traumatic event, the Mentel page. Black, White, atc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Laborer Tobacco Factory 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles B. Eaton Nannie Callum 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 6318 Chew Road Upper Marlboro, MD Robert G. Eaton - Son 20a. Mathod of Disposition
143 Burlal 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) Deta 20c. Location - City or Town, State Richmond, VA 5/20/00 Oakwood Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensas 22. Name and Address of Facility
Metropolitan Funeral Service, Inc. Cl900 5517 Vine Street Alexandria, VA 22310 Part 1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only ona cause on each line. Approximate Intarval Batween Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ACUTE MYOCARDIAL INFARCTION Examiner MORE THAN Physician/Medical Examiner D.ATHEROSCLEROTIC CARDIO VASCUUAR DESEASE The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. Box 68760, Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL DISEASE Division of Vital Records, 24b. Were autopsy findings available prior to complation of causa of death? is certificate has been si director, page 2 should Completed 24a. Was an autopsy ATRIAL FIBRILLATION 1 Yas 2X No 1 ☐ Yas 2 ☐ No Amending Physician: Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) Hospital: 1.⊠Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Affer this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) Certification 28b. Tima of 28d. Describe how injury occurred 5 Panding investigation 1 Natural death. 1 Yes 2 No after death Director: A d in by the 5 2 ☐ Accidant 3 Suicide 6 Could not be determined in by t 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Medical 15 Certifying Physician: To tha best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifier yan cho 5-15-2000 D 50653

State Registrar

DHMH 16 Rev 6/95

5851 Deale-Churchton Rd. Deale, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

32. Registrar's Signature

Gyan Surana, MD 31. Data filed (Month, Dey, Year) MAY 3 1

1,035

Commission of the Control of the Con

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

17282

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1/11am May 19, 2000 5:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health and Rehabilitation Center Annapolis Anne Arundel If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2□F Hours Director 220-32-6439 1907 Maryland February 4, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show 1 √ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 233 Farragut Road United States deeth Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, atc. permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event, the Middle Lemman. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 □ Never Married 2 □ Married 21215-0020 1 Yes 2 No Specify: ģ Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Farmer Agriculture Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Elben Neva (maiden surname unavailable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Elben / Daughter 233 Farragut Road Annapolis, MD 21401 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 05-23-00 Hillcrest Memorial Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland 22. Nama and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Furniral Service Licenses 147 Duke of Gloucester St. Annapolis, MD 21401 name, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. Luronly ona cause on each line. 23a. Partf. Efter the diseas shock, or heart failure. Approximata Intarval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Som 1 The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Bud Dua to (or as a consequence of): physician at the burie Box 68760, COLONNI Due to (or as a cons quence of): P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. cata has been signed by the a page 2 should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No certificata 1 Yes Division of Vital or Attanding Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 110 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manger of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 Yes 2 No 24 hours after death. 2 Accident the within 24 hours after des To the Funeral Director completely filled in by th 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Intertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical ş 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) DI Chevery M.D 20785 30 Matter and address of person who completed cause of death (Item 23a) (Type, Print) \ awa Koh Vade 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JANY 2 2 2000 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7283 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Deeth May 12 2000 803am Inga Britta Elgcrona 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 8. Date of Birth (Month, Dey, Year) Mar. 29,1928 7. Age (In yrs. last birthday) If Under 1 Year | Months Deys If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country)
 NY 6. Sex 1 M 2 F YES. 107-20-9788 72 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Montgomery Potomac 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8717 Hidden Hill La 20854 United States 12. Was Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritel Stalus 1 Yes 2XNo If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 20XNo Specify: White Specify 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Instructor Musician 18. Mother's Name (First, Middle, Maiden Surname)

Sigrid Kunigunda Terhi

Dete

14,2000

May

933 Gist Ave. Silver Spring, MD 20910

20c. Location - City or Town, Stata

Beltsville, MD

May 13,2000

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

13416 Running Pump Ct. Oakhill, VA 20171

22. Name and Address of Facility
Rapp Funeral & Cremation Services

permit. Pages 1 and 2 should be tile.
Department of Health and Mental Hy,
Important: if them 27 is marked off-Physician /Medical

The law requires that the death certificate be executed

or Attending Physician:

death.

this

Division of Vital Records, P.O. Box 68760,

Saltimore, Maryland 21215-0020

Examiner

Physician

/Medical

Examiner

Funeral

Director

natural", or items 23a or 28a-f show dical Examiner must be notified at

Director

Funeral

á

Completed

Be

2

17. Father's Neme (First, Middle, Last)

20a. Method of Disposition

Carl Uno Elgcrona

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Funeral Service Licenses

19e. Informent's Neme/Reletionship (Type, Print)

Radford Schantz/son

1 ☐ Burial 2XXCremation 3 ☐ Removel from State

Physician/Medical Examin physician and s the burial-transit signed by the PV Completed has Be Medical Certification: To To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu 10

31. Date filed (Month, Day, Year)

MAY

23a. Part1. Enter the disease, or com shock, or heert failure. List only	plications thet caused the dea one cause on each line.	th. Do not enler the mo	ode of dying, such as cardia	ac or respiretory errest,	Approximata Intervel Between Onset end Deeth
Immediate Cause (Finel disease or condition resulting in death)	a Adult Respi	ratory Dis	tress Syndro	me.	1
rosumy in coamy	Due to (or es e consequence of):		
Sequentially list conditions.	b. — Due to (or es e consequence of):		1
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events					
that initieted events resulting in death) Last	Due to (or es a consequence of):		
	d				
Pert II. Other significant conditions of	ontributing to death but not re-	sulting in the underlying	cause given in Pert I.	23b. Did tobacco use co	ntribute to the cause of death
Metastatic Canc	er			1 ☐ Yee 2 No	3 Probably 4 ☐ Unknow
	Land Q			24a. Wes en autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
Great Control				1 ☐ Yes 2 ₺ No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			26. Place of De	seth (Check only one)	
1☐ Yes 2☐ No	Hospitet: 1 Inpatient 2 □	ER/Outpatient 3 [OA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Manner of Deeth N∑Neturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	red
3 Suicide 6 Could not be determined		ome, ferm, street, fectory)	ery, office	28f. Location (Street end Numb City or Town, Stete)	ber or Rurel Route Number,
				ce, end due to the cause(s) and ma curred et the time, date end plece,	
29b. Signature and title of certifler	Λ Λ		9c. License number	29d. Date signe	d (Month, Day, Year)

29c. License numbe D42518

20b. Plece of Disposition (Name of cemetery, crematory or other plece)

Chesapeake Crematory

DHMH 16 Rev 6/95

State

Registrar

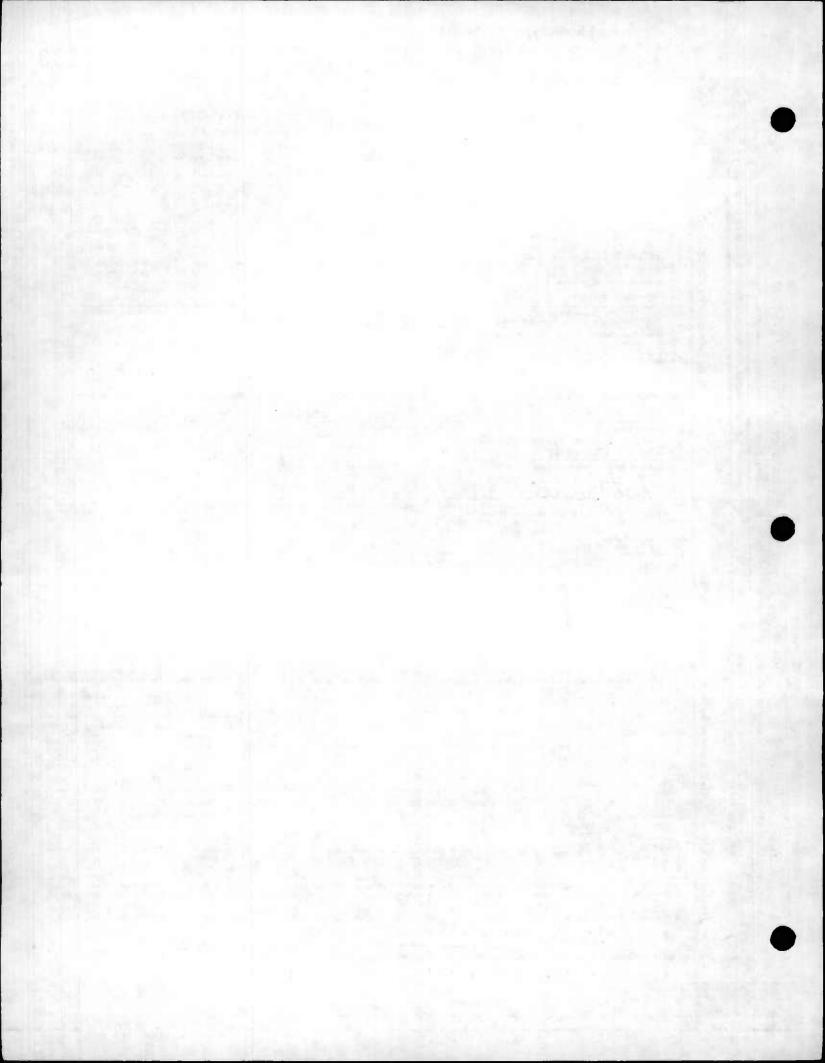
Gul Chablani M.D. 11119 Rockville, Pk. #401, Rockville, MD 20852

relleur

32 Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dele of Deeth 3. Tima of Death Mach **Physician** Trickson 2:40 AM 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Dee Examiner HOPK HHORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) June 24, 1947 Virginia If Under 1 Year 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Deys Hours 1⊠M 2□ F 52 Yrs. 220-50-9545 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2♥ No the Medical Examiner must be notified Directo Maryland Montgomery Silver Spring fisms 23s or 28s-f 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 20905 25 Locustwood Court **IISA** Funeral 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 72 hours after 1 ⊠Yes 2 No If Yes, Give Farly Yeer or Detes 1970's 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) ould be filed within Mental Hygiene. al Hygiene. Elementery/Secondary (0-12) 12 Software Training College (1-4or 5+) Owner/Operator and Consulting 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Health and Menta am 27 is marked Bruce G. Erickson, Sr. Marjory Welch permit. Pages 1 and 2 should Department of Health and Men Important: If tem 27 is merites 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 25 Locustwood Court, Silver Spring, Maryland 20905 them 27 other tri Carol A. Erickson / Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 6 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Fort Lincoln Crematory 05/17/00 Brentwood, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) ture of Funeral Se 22. Name end Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 23a. Part1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only oper cause on each line. Approximete Interval Between Onset end Deeth **Physician** Metastation /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner transplan Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): and Box 68760, physician **Physician/Medical** the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by i þ 24e. Wes en autopsy performed? 24b. Were autopsy findings available prior to Completed peen completion of ceuse of deeth? **page 2** has 1 ☐ Yes 2 No this certificate 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpalien 2 ☐ ER/Oulpalient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 28d. Describe how Injury occurred After 5 Pending investigation Division Attending s after deam. 1 Neturel 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - Al home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 6 Hospital To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner stated. Medical 29e. Certifier (Check only 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier 2000

Registrar

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WOLFE

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30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

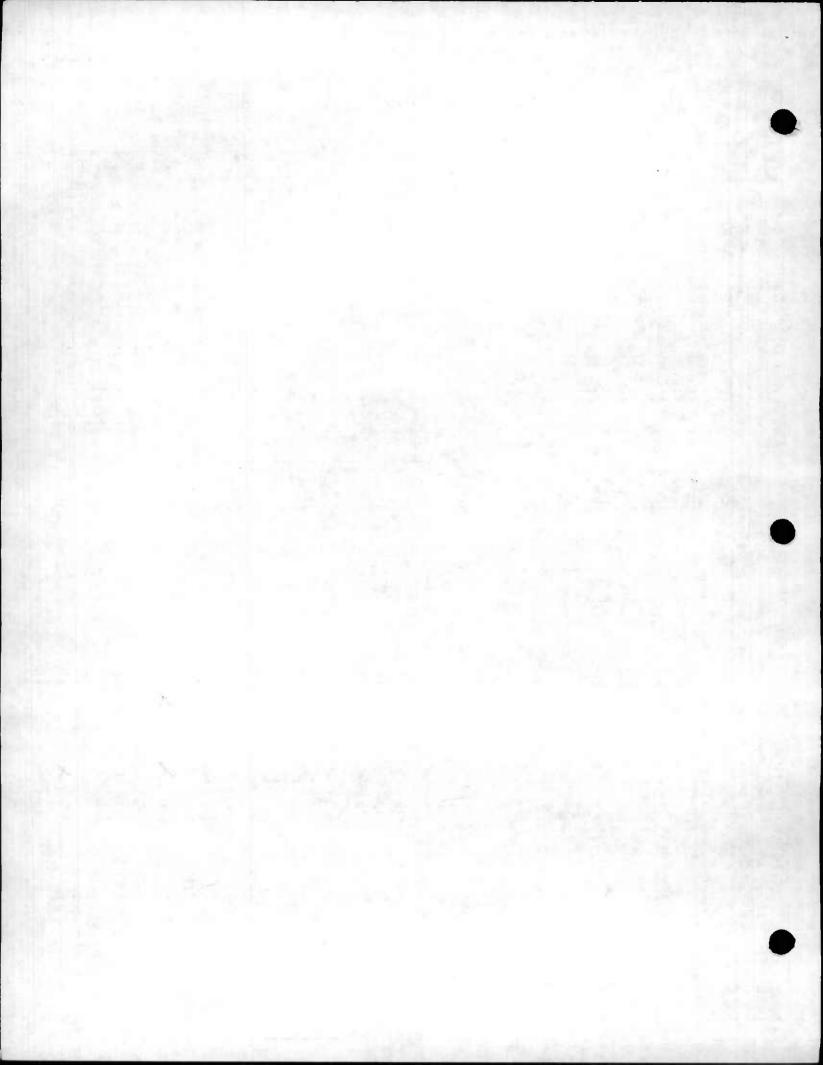
2000

OBEN6

31. Dete filed (Month, Dey, Year)

JOHNS

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7285 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1444 ESTEVAO 01510 14 1000 WUYZ 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 13836 TARIONA DRIVE SILVER SPRING MONTFORWAY If Under 1 Year | If Under 24 Hrs. Birthpiace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Days Months Hours M 2 F Yrs MAY 10, 1968 BRAZIL NONE Usuai Residence of Decedent 10d. inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No MD. MONTGOMERY SILVER SPRING 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 13836 BRAZIL TABIONA DR. 20906 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Biack, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Eiementary/Secondary (0-12) 12 HANDYMAN SELF EMPLOYEED 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) ESTEVAO JOAO LUIZ CECILIA MARIA DO CARMO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) IZABEL CRISTINA NOGUEIRA/WIFE SAME AS TTEM 20b. Pieca of Disposition (Name of cemetery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State 1 WBuriel 2 ☐ Cremetion 3 ☐ Removei from State 5/22/00 PAZ 4 ☐ Donetion 5 ☐ Other (Specify) CMITERIO DA BELO HORIZONTE, BRAZIL 21. Signature of Funeral Service Li 22. Name and Address of Facility MO0091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) DEATH BY HANGING Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of) 23b. Did tobacco uee contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 XNo 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 NO 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner**

Physician

Examiner

10a. State

Directo

Funeral

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Completed

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2

Funeral

Director

in than "natural", or items 23s or 28s-1 show, the Medical Examiner must be notified at

perms. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mentel Hygiens. Insportant: If them 27 is marked other than "natural; or its any injury or other traumatic event, the Mourel Enterine

Baltimore, Maryland 21215-0020

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/Medical

sician and burial-transit The law requires that the death certificate be executed physician s the burial USB aS ed by the a datached f signed b should !

Examiner paga 2 certificata director After this funeral aftar deeth. Director: Af To the Hospital or Atta within 24 hours aftar der To the Funeral Directo completaly filled in by th Medical

Division of Vital Records,

Hospital or Attanding Physician:

lan/Medicai Physic þ Completed Be 0 Certification:

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Sulcide

29a. Certifier

State Registrar at title of certifier

2000

5 Pending

investigation

6 Could not be determined

16

29c. License number

28f. Location (Street and Number or Rurel Route Number, City or Town, State) 1393 (The OD) OR, SILVER SPAINS, MO 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the besis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

SELF INFLICTED - HANDING

28d. Describe how Injury occurred

29b. Signati MAY 14, 2000

28b. Time of

28e. Piace of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Injury

1200 M

HOME

28a. Date of injury (Month, Day Year)

4/14/2000

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

CALL I. WARGOLS, MC (ME) 11125 Rackville 81th, Lockville MO 20852 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature

28c. Injury at Work?

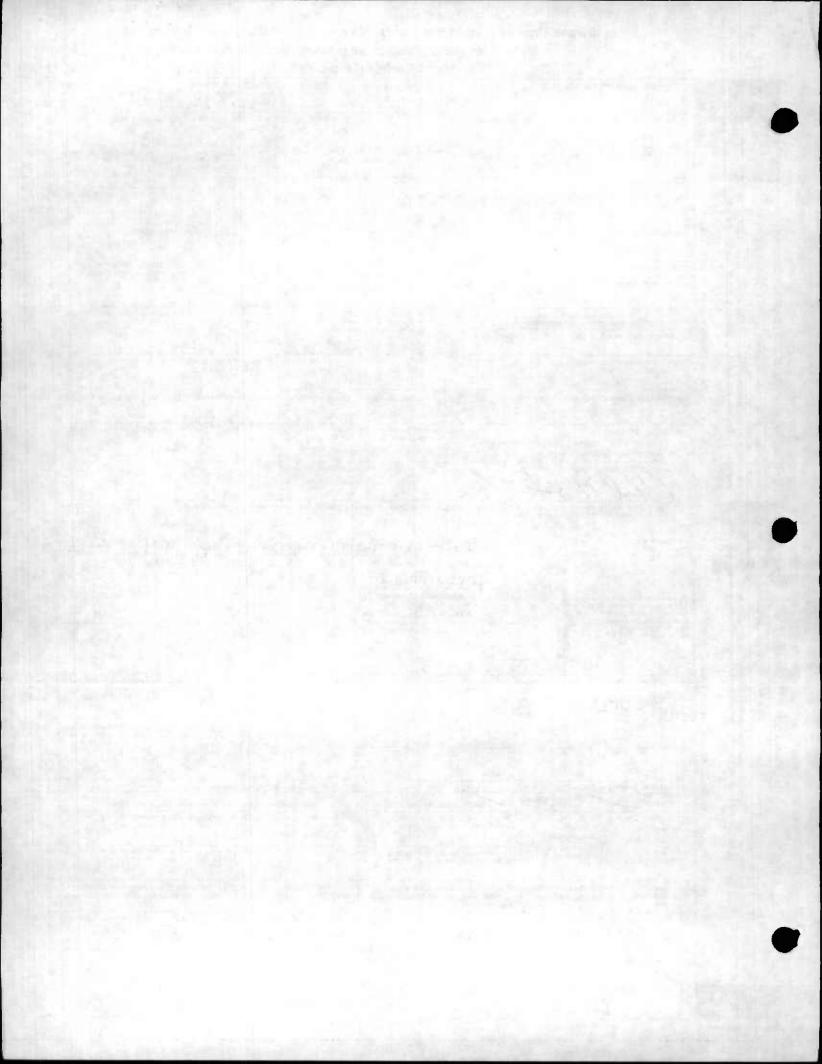
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Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

		Certificate of Death	Reg. No. UU 17286							
Physician	1. Decedent's Nama (First, Middla, Last)		2. Data of Death Month Day Year							
/Medica	JANICE MARIE FUSIER	4b, City, Town, or Loc	May 10, 2000 1300							
Examine										
	The Memorial Hospital 5. Social Security Number 6. Sax 7. Age (In yrs. la.	Easton If Under 1 Year If Under 24 Hrs.	8. Data of Birth 9. Birtholaca (State or Foreign							
Funeral Director	213-42-2313 1 M 2 F 56 Usual Rasidence of Decedent	Yrs. Months Days Hours Min.	8. Data of Birth (Month, Day, Year) MAR. 20, 1944 9. Birthplaca (Stata or Foreign Country) MARYLAND							
and 21215-0020 be filed within 72 hours after death with the Manyland lail hygiene. d other than "natural", or thems 23s or 28s-f show event, the Medical Exercines must be notified at	10a. Stata 10b. County 10c. City,	Town or Location	10d. Insida City Limits 1 ☐ Yas ঽ\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\							
Uifer death with the Ma	MD QUEEN ANNE 'S 10e. Street and Number	CENTREVILLE 101. Zip Code	10g. Citizen of What Country?							
Sa or	306 NORTH COMMERCE ST.	21617	USA							
death death	11. Marital Status 12. Was Decedent Evar in U.S.									
Danice Foster Baitimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or home 23a or 23a-f ahow any liquity or other traumatic event, the Medical Exercities must be notified at page.	3 ☐ Widowed 4 ☐ Divorced Yaar or Datas:	1 ☐ Yes 2 ☒ No Specify:	Black, White, etc. Specify: WHITE							
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Should Brown Mend Mend Mend Mend Mend Mend Mend Men		19b. Mailing Addrass (Street and Number or Rura.								
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Janice Baltimore, permit. Pages 1 ar Department of Hea Important: If them 2 may Injury or other pages.	1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramoval trom Stata 4 ☐ Donation 5 ☐ Othar (Specify) CHES		-13-00 CENTREVILLE, MD 21617							
Balt Pemit. Departi Importa any Inju	21. Signatura Funeral Service Licensee		& NEWNAM FUNERAL HOME, P.A.							
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	Demini Em tack	X) H55274	5/10/00							
	30. Name and address of person who completed causa of death (Item 2 JEANNE EINFALT, M.D., 219 S. W.	(3a) (Type, Print) ASHINGTON ST., EASTON, N	4D 21601							
State	31. Data tiled (Month, Day, Year) 32. Registrar's Signatu									
Registra	MAY 1 2 2000	, a popular								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		Decedent's Name (First, Middle, La.	-4)	Ce	rtificate of	Death		Reg. No.	17287	
Ph	nysician						2. Date of De Month May	Dey	3. Time of Deeth	
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	neral ector	5. Social Security Number 6. S 217-24-1082	ex 7. Age (70 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, De Oct	th Yeer) 2 1929	9. Birthplace (State or Foreign Country) MD	
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2 %	be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	nat Country?	
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ar ded	j 5	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Even Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates:	er in U,S. 13.		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No Rican, etc.)		- American Indian, , White, etc. White	
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d Maria	T T	19a. Informant's Name/Relationship		10h Mai	ing Address (Ctros	at and Number or Rur		·	Itata Zin Cada)	
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	De.	20a. Method of Disposition					Date		wn, MD 21136	
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To the within	W	29b. Signature and the of certifier	Mul	& MD	29c. Licer	rse number 39 L		29d. Date signed	(Month, Dey, Year)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7288 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Wilma F. Fleming 19, May 2000 8:10 am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Towson Gilchrist Center @ GBMC If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Montha Deys Hours 1□ M 21 F Yrs. Director March 23, 1935 Maryland 214-32-4953 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limita Ellicott City 1 Yes 2 No Maryland Howard Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21043 United States 2825 Brian Ct. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busineas/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Registered Nurse Healthcare 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Franklin Reese Edna Lipps 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2825 Brian Ct. Ellicott City, MD. John F. Fleming, Jr. / spouse 20b. Ptece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 23 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 2000 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland Lorraine Park 21 Signature of Funeral Service Licensee 22. Neme end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043 NOTOGN 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Lung CAncer Examiner Due to (or es a consequence of) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled events resulting in death) Last Due to (or es e consequence of): the burial-trar Physician/Medical Due to (or es a consequence of) Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the ceuse of death? 1 Tes 2 No 3 Probably 4 Unknown Completed by page 2 should be 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes an eutopsy performed? 2 NO 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

completely

Medical

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Pages 1 and 2 should be nent of Health and Mental

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

certificate

this

After

Hospital or Attending
 24 hours after death.
 Funeral Director: After

within 2 To the

2000

31. Dete filed (Month, Day, Year) MAY 1 9 2000 Registrar

29a. Certifier

(Check only one)

29b. Signatury and after of cardifie

A. Riley

32. Regigirer's Signeture

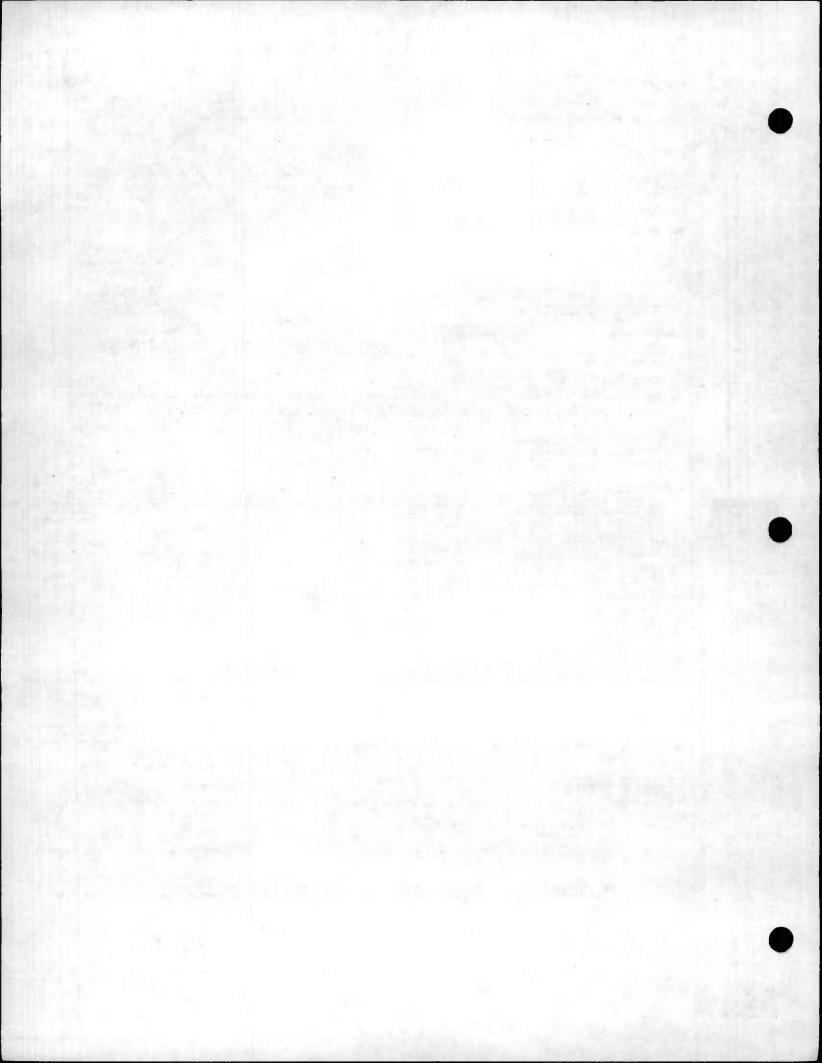
who completed cause of death;

Charles St. Balfo. md 21205 6701

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner ea stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner_stated.

29d. Date signed (Month, Day, Year)

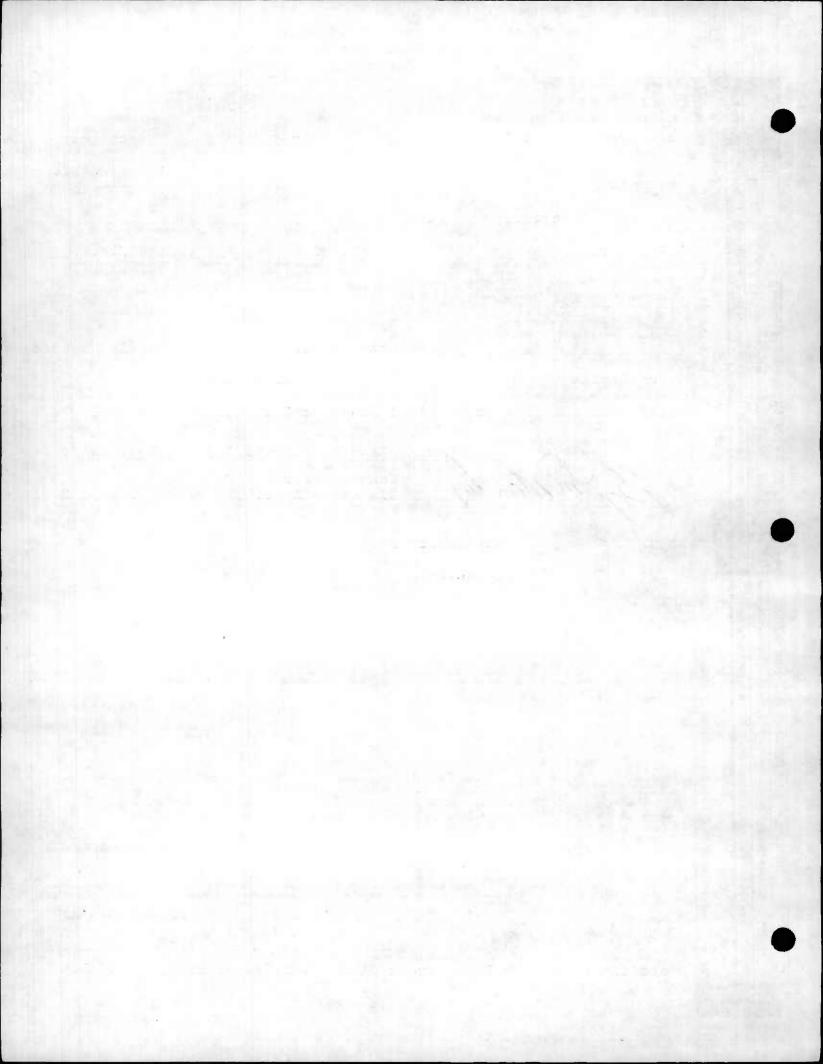
Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

		Certific	ate of L	Death	R	eg. No.	0 1/20:
1. Decedent's Name (First, Middle, La	est)				2. Dete of Deat Month		3. Time of Deeth
PEARL	FAIRV	VEATHER			May 16		5:40 A
4a Fecility Name (If not institution, give	ve street and number)		4	b. City, Town, or	Location of Death	4c. County of	f Death
Holy Cross Hos			S	ilver	Spring		ntgomery
	Sex 1 □ M 210 F 7. Age (In yr 8 4	Yrs. Ist birthday) If Un Mont		Hours Min	(Month, Day	Year) 26,1916	9. Birthplece (Stele or Forei Country) Calf.
10a. State 10b. County	10c.	City, Town or Location					10d. Inside City Limi
Maryland Mont	gomery	Rockville					1 □ Yes 2X0N
Maryland Mont 10e. Street and Number	50		Zip Code		1	Og. Citizen of Wh	nat Country?
1 1 5 / 0 5 37 .	s Way		2085	3		United	States
11. Marital Status 1 Never Married 2 Married 3 Ct. Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		- American Indien, White, etc.
		16a. Decedent's U	Isual Occupa	ntion		16b. Kind of Bus	White
15. Decedent's Elementary/Secondary (0-12) 1 2	ade completed) College (1-4or 5+)	(Give kind of life. DO NO	work done d Tuse retired,	luring most of wo)	rking		ale Manufac
17. Fether's Name (First, Middle, Last,)	ASSEMBI	y WOI		me (First, Middle, I		
Henry Levine				Ros	e Stern		
19a. Informant's Name/Relationship ((Type, Print)	19b. Meiling Add	ress (Street a	and Number or R	ural Route Number	, City or Town, S	tete, Zip Code)
David Fairweat	her / Son	8401 B	radmo	or Dr.	Bethes	da, MD	20817
20a. Method of Disposition	206	. Place of Disposition (cemetery, cremetory	Neme of or other plece	9)	Dete	20c. Location - C	ity or Town, Stete
1 Burial 2 Cremation 3 4 Donation 5 Office	Tueurovei irom State	press La		1	05/19/0	O Colma	Colf
21. Signature of Europed Service Men		Activity and a second	e end Addres		03/13/0	O COIMA	i, Call.
	1			uneral	Home		
4 Jug/10	1 (Centry)					shingto	n, DC 2001
23a. Int. Enter the disease, or combook, or have tellure. List only temmediate Cause (Final disease or condition		itory Fai		g, such es cardia	Correspiratory em	851 ,	Approximate Intervet Between Onset and Deeth
resulting in death)	8.	(or as a consequence					1
	Pneumon	ia				•	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due Io	(or es e consequence	of):				
Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or es a consequence	of):				
	d				TEU		1
Part II. Other significant conditions of	contributing to death but not re	esulting In the underlyin	ng cause give	en in Pert t.	23b. Did to	bacco use cont	ribute to the cause of deat
Part II. Other significant conditions of					1 🗆 Y	es 2 No 3	3 Probably 4 Unkno
COMPLETE					24a. Wes a perform		24b. Were autopsy findings eveilable prior to completion of cause of death?
					1 U Y	s 2 XNo	1 Yes 2 No
E							
25. Was case referred to medical				26. Place of De	ath (Check only on	e)	
25. Was case referred to medical examiner?	Hospitel: V V	☐ ER/Outpatient 3☐	DOA Othe	Mr.	ath (Check only on		(Specify)
25. Was case referred to medical examiner? 1 Yes 2 X No	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. tnjury Work	97: 4□ Nursing I	lome 5 ☐ Reside		
25. Was case referred to medical examiner? 1 Yes 2 X No	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury M	28c. tnjury Work	97: 4□ Nursing I at .?	forme 5 ☐ Reside 28d. Describe ho	ence 6 Other	
25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At	28b. Time of tnjury M home, ferm, street, feccify)	28c. tnjury Work 1 🗀 V	e, date and place	one 5 ☐ Reside 28d. Describe he 28f. Location (Si City or Town	once 6 Other ow injury occurred reet end Number or, Stete)	or Aurel Route Number,
25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At building, etc. (Spe	28b. Time of thijury M home, ferm, street, fecity) nowledge, death occurnetion and/or investigat	28c. tnjury Work 1 🗀 V	at .?? 4 Nursing I at .?? Yes 2 No	28d. Describe he 28f. Location (Si City or Town a, and due to the curred et the time, d	once 6 Other ow injury occurred reet end Number n, Siete) ause(s) and meniate and plece, ar	or Aurel Route Number,
25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At building, etc. (Spe	28b. Time of thijury M home, ferm, street, fecity) nowledge, death occurnetion and/or investigat	28c. tnjury Work 1 1 totory, office	e, date and place inition, deeth occionumber	28d. Describe he 28f. Location (Si City or Town a, and due to the curred et the time, d	price 6 Other ow injury occurred reet end Number n, Stete) ause(s) and men ate and plece, ar	or or Rurel Route Number, ner es stated. Indidue to the cause(s)
25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At building, etc. (Spe nysician: To the best of my k miner: On the basis of exami and menner steted.	28b. Time of tnjury M home, ferm, street, feocify) nowledge, death occurnation and/or investigat	28c. tnjury Work 1 1 totory, office	at .?? 4 Nursing I at .?? Yes 2 No	28d. Describe he 28f. Location (Si City or Town a, and due to the curred et the time, d	once 6 Other ow injury occurred reet end Number n, Siete) ause(s) and meniate and plece, ar	or or Rurel Route Number, ner es stated. Indidue to the cause(s)
25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At building, etc. (Spe 19aiclan: To the best of my ke miner: On the basis of exami and menner steted.	28b. Time of tnjury M home, ferm, street, feocify) nowledge, death occurnation and/or investigat	28c. thiury Work 1 1 totory, office red et the tim tion, in my op 29c. License	e, date and placeinion, deeth occur	and due to the curred et the time, d	price 6 Other ow injury occurred reet end Number n, Stete) ause(s) and men ate and plece, ar	or or Rurel Route Number, ner es stated. Ind due to the cause(s) (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7290 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Day Month **Physician** May 15, Shirley Mary Ann Fisher 2000 11:50PM /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Olney
If Under 24 Hrs.
Hours | Min. Montgomery General Hospital Montgomery if Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Yeer) **Funeral** Months Deys 1 ☐ M 2 🕱 F Yrs Director 59 Jan. 27, 1941 Michigan 369-40-2492 Usuel Residence of Decedent with the Marylend worle ! 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f ebov other treumstic event, the Medical Examinal must be notified at 1 Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20904 death \ 12411 Loft Lane USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Healin and Mental Hygiens.

Theorem: If feen 27 is marked other than "natural; or file may injury or other treumatic event, the Mastral Examina 1 ☐ Yes 2 ☑ No tf Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 1 Divorcad White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 4 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be To Anthony Joseph Covitz Mary Theresa Wojciechowski 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kimberlee A. Broadie 12411 Loft Lane Silver Spring, Maryland 20904 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date b 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 5/18/00 Silver Spring, Maryland 21. Signature of Funeral Se 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complication that caused the death. Do not e shook, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediate Ceuse (Finel INFARCTION MYDCARDIAL disease or condition resulting in deeth) Examiner Due to (or as e consequenca of): Examiner FOOT OSTEOMYELITIS Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last physician end the buriel-tran Due to (or es e consequence of): certificata be execu DIABETES DEPENDENT TNSULIN Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): as attending plant of the use as been signed by the a should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown þ 24b. Were eutopsy findings evalleble prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? 2X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital after death.

Director: After this certifica funeral director, 25. Wes case referred to medical Be 26. Piece of Death (Check only one) examiner? Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funerel Directo completaly filled in by the 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner steted. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Han Kany D0055054 16,2000 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) ROCKVILLE, MD KASID REDLAND AV.

Registrar

State

31. Date filed (Month, Dey, Year)

MAY 18 2000

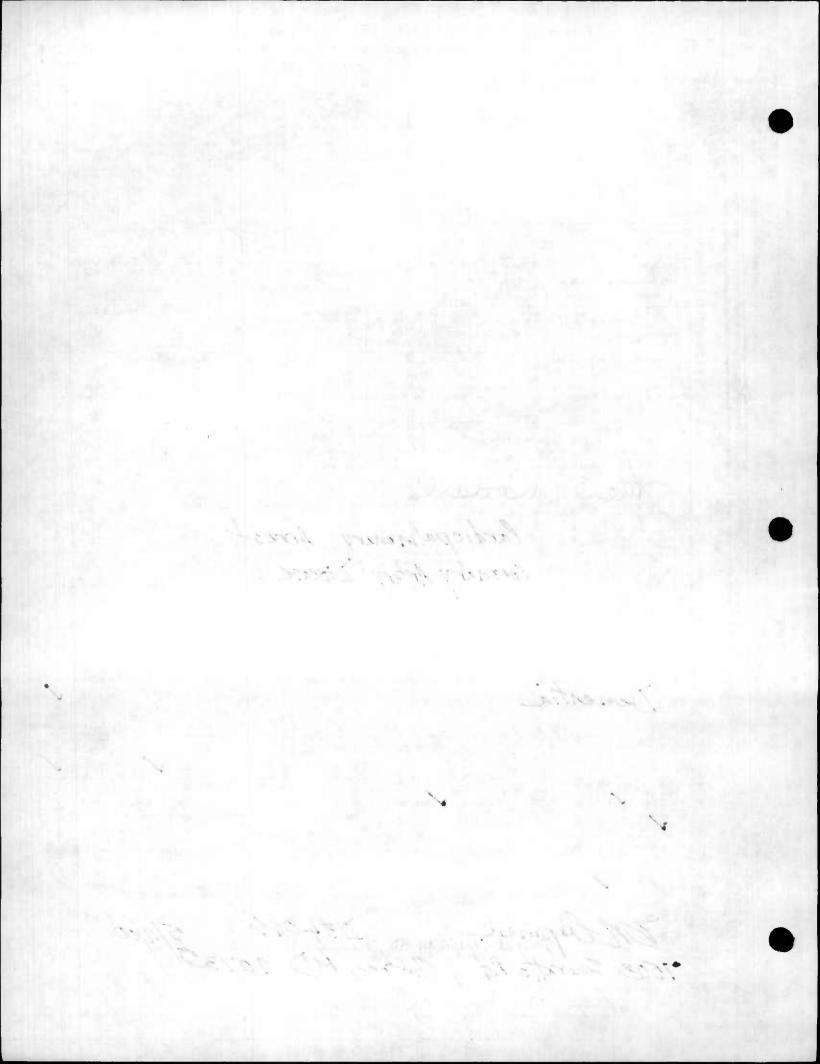
32. Registrer's Signeture

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Please Type or Print in Biack indelible Ink. Assure Ali Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 17291

			C	ertificat	e of	Death		R	eg. No.	112	71
Physician	Decedent's Nama (First, Middla, La Ruby		erald					Deta of Deal Month ay 11		'ear	of Death
/Medical			eraid			4h Chi Tour					10 AM
Examiner	4a Facility Nama (If not Institution, giv Southern Maryla					4b. City, Town		n of Death	4c. County of	George 1	e
Funeral	5. Social Security Number 6. S	ax 7. Age (In)	rs. last birthde		1 Year	If Under 24	4 Hrs Tor	ata of Birth		9. Birthplace (Stet)	
Director	229-50-0086 1 Usual Residence of Decedent	□ M 2□XF 7	O Yrs.	Months	Days	Hours	Min.	Month, Day arch	12, 1930	Virgi	nia
wo m	10a. Stata 10b. County	10c.	City, Town or	Location						10d. Inside	City Limits
Man, Hah	MD P.G.		Oxon H	i 11						1 🗆 Ya	as an No
or 28	10e. Street and Number	1		10f. Zij				1	0g. Citizen of Wh	at Country?	
ath w	5712 Arapahoe Dri				207				USA		
n 72 hours effer death with the Maryland "natural", or frame 23a or 28a-f ahow edical Examiner must be notified at leted by Funeral Director	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:	n U,S. 1			tispanic Origi an, Mexican, i Specify:	in? (Specify Puerto Ricar	pecify Yes or No- o Rican, etc.) 14. Race - Ame Black, Whit Specify:			
72 ho 72 ho natur for	15. Decedent's Ec	ducation	16a. De	cedent's Usu	al Occup	pation during most o	of working		16b. Kind of Busi		
	Elementary/Secondary (0-12)	College (1-4or 5+)		us Dri		during most of d)				vania Co	
filed within Hygiene. ther than out, the Handle of Comp	12 17. Fathar's Nama (First, Middla, Last)		Ь	us DII	ver	10 Mothod	h Name (Fig	nt Afiddio I	Virgini Waiden Sumama)	a School	Syste
d 2 should be filed within 72 hours eff and Mental Hygiene. If is marked other than 'natural', or trainmatic event, the Medical Essent To Be Completed by F	Thomas Barksdale						garet		ESCHIE DESC.		
hould be marked o marked o	19e. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address	s (Street				City or Town, Si	ata, Zip Code)	
	Bernice Waller -			_					111, MD		
semil. Pages 1 and 2 should be filed within pages 1 and 2 should be filed within pages in marked cliner than my injury or other traumatic event, the Manage. To Be Comp	20a. Mathod of Disposition 10 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State	ce) Ch. C	May	18	20c. Location - C	ty or Town, Stata	nia			
orten Injura	21. Signature of Funaral Sarvice Licer		nerrys			ess of Facility		700	Gliacha	m, viigi	пта
Desmit Depart Import any inj	Muon 1	. Woods	1900	Metr	opo1	itan F	unera	l Serv	vice, Indria, VA	22310	
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The late he page								1 🗆 Y	s 20 No	1 ☐ Yes 2	No
certificate has rector, page 2	25. Was casa rafarred to medical examiner?					26. Place o	of Death (Ch	eck only on	e)		
hys hys	1 ☐ Yas 2 ☑ No 27. Menny of Death	Hospital: 1 Inpatient 2 28a. Dete of Injury (Month, Day Year	28b. Time	of :	OA Ott				once 8 Other		
trendin death. ctor: Afr y the fur Catio	1 ■Natural 5 □ Panding invastigation		, ,,,,,,	М		Yes 2□N	0				
tal or Attending P is after death. In Director: After t led in by the funer Certification:	3 Suicide 6 Could not be determined	street, factor	y, office		28f. I	ocation (Si City or Town	reet and Number n, Stele)	or Rural Routa No	ımber,		
To the Hospital within 24 hours: To the Funeral completely filled	29a. Certifler (Check only one)	ysician: To the best of my lainer: On the basis of axam and mannar stated.	knowledge, de ination and/or	ath occurred investigation	at the tie	me, date and opinion, death	place, and d occurred at	lue to the c the time, d	ause(s) end meni ate and place, an	ner as stated. d due to the cause	e(s)
To the within To the comple	290. Sadature and littingel certified	man	40	29c, License number 2666				29d. Data signed (Month, Day, Year))
S	30, Name and address of person who	completed cause of death (MON M	Do. Print)	1	1/>	207	73	5//		
	31. Data filed (Month, Day, Year)	32. Registrar's Si	CIM	10-0			0				
State - Registrar	BARY 1 = 20	100 Seneral	1	6	a. W						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7292 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath 3. Time of Death April 30, 2000 Year **Physician** 3:15 A.M. James Albert /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death Examiner 627 Robbie Court Aberdeen Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours XXM 2 F 479-24-1252 72 Yrs. **Director** July 26, 1927 Iowa Usual Rasidence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumstic event, the Medical Examinar must be not industed. XXYes 2□No Director Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 627 Robbie Court 21001 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Koro Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritai Status Biack, White, atc. Armed Forces?

1 X Yes 2 No Korea
If Yes, GiveVietnam
Year or Dates WW II 1 ☐ Navar Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2000 Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Eiementary/Secondary (0-12) College (1-4or 5+) Test pilot/logistics Civil Service 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James R. Garner Zella Hopkins 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Ruth P. Garner (Spouse) 627 Robbie Ct., Aberdeen, Maryland 21001 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cramation 3 □ Ramoval from Stata 5/5/00 4 ☐ Donation 5 ☐ Other (Specify) Drakesville Cemetery Drakesville, Iowa 21. Signature of Funeual Service Licansee 22. Name and Addrass of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Physician Immediata Causa (Final disease or condition resulting in daath) /Medical EARS **Examiner** Due to (or as a consequence of) Physician/Medical Examiner anding physician and use as the bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immediata ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of) fo signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part f. 23b. Did tobacco usa contribute to the causa of death? 1 □ Yes 2 No 3 Probably 4 Unknown (tas tase by 24b. Were autopsy findings available prior to completion of causa of daath? no vascular accident 24a. Was an autopsy page 2 should Completed peed certificate has 1 ☐ Yes 2 No 2 No 1 Tyes ai or Attending Physician: The safter death.

I Director: After this certificated in by the funeral director, page to be seen and the s 25. Was casa refarred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28c. injury at Work? 28b. Time of Certification: 5 Panding invastigation 1 Natural 2 Accidant injury 1 Yes 2 No To the Hospital or Atterview within 24 hours after decorpt to the Funeral Director complataly filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 I Homicida time Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signature and title of certifier

ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signatura

2000

tenu Ave. - A Building RM#11

Baltimone Mis 21224

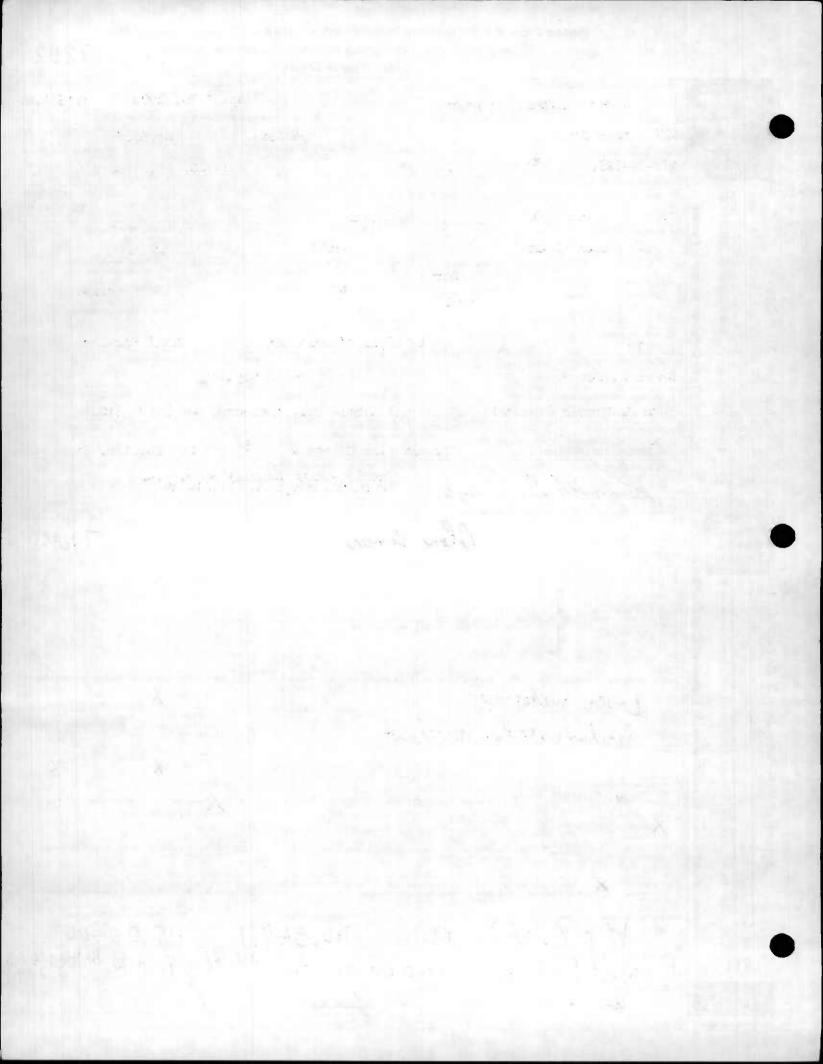
1041

P.O. Box 68760

Division of Vital Records,

State Registrar 30 Name and address

ODRIGO 31. Data filed (Month, Day,



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygien | 7293

						Ce	rtificat	te of L	Death		Reg. No.		
Dh	volois	200	1. Decedant's Nama (First, Middla,	Last)						2. Data of De	ath Day	Yaar	3. Tima of Death
	ysicia Vedic	_	Betty A	nn Griffi	n					May 4,		raai	10:05 AM
	amin		4a. Facility Nama (If not Institution, g	iva street and num	bar)			4	b. City, Town, o	r Location of Daath		of Death	
			564 Jamestown C	t H					Edgewo	od	Ha	rford	
Fun	eral		Social Security Number		. Aga (In yrs.	last birthday)	If Unda Months	r 1 Yaar Days	if Undar 24 Hr Hours Mir		th Vene	9. Birthple	aca (Stata or Forai
Direc	ctor .		220-74-3786 Usual Rasidance of Decedant	1 □ M 2 1 1 F	44	Yrs.	1410111113	Days	riouis iviii	Dec. 2		Washi	ington
rland ow	12	Ì	10a. Steta 10b. County		10c. Cit	ty, Town or Lo	ocation					10	d. Inside City Limit
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Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Jerry Wilton Gilbert May 3, 2000 1:40 AM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Months | Days | Hours | Min. | (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Days 15℃M 2□ F Virs 212-16-9172 84 March 4, 1916 Maryland Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Harford Havre de Grace 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3704 Rock Run Rd. 21078 USA 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Merried 1 NYes 2 No W Yas, Give Year or Dates: 1945-46 1 Yes 25 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Artillery Inspector Supervisor U.S. Government 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Nolan Scott Gilbert, Sr. Anna Isabell Gilbert 19a. Informant's Name/Reletionship (Type, Print) Wife 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Bessie Marquerite Gilbert/ 3704 Rock Run Rd., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 5-6-00 Havre de Grace, Maryland Rock Run U.M. Cemetery 21. Signafure of Fundrat Service Licenses 22. Name end Address of Fecility McComas Funeral Home, P.A. horses a. Emal 23a. Pert1. Enter the disease, or complicate is that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory errast,

Approximate

Approximate Approximate Intarval Between Onsat end Deeth Immediete Cause (Final disease or condition resulting in death) STAPHYLOCOCAL BACTERIAL ENDOCARDITIS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yee 2 ☑No 3 ☐ Probably 4 ☐ Unknown STAGE RENAL FAILURE 24b. Were autopsy findings avellable prior to 24e. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Pages 1 and 2 should be t Department of Health and Mental I Important: If Item 27 is marked of any injury or other treumatic eve

3altimore, Maryland 21215-0020

Physician

/Medical

Examiner

Directo

Funeral

Director

Physician/Medical Completed B Certification: To

A Hospital or A. 18 24 hours after death.

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Within 2 To the I ŝ

> State Registrar

Medical

29b. Signature and title of certifier

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical examiner? 26. Place of Death (Check only ona) Hospitel: 1 Ahpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 TYes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Corritying Physician: To the best of my knowledge, deeth occurred et the time, data end place, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number Andew Nowalearly MD

29d. Date signed (Month, Dey, Year) DO8096 MAY 3, 2000

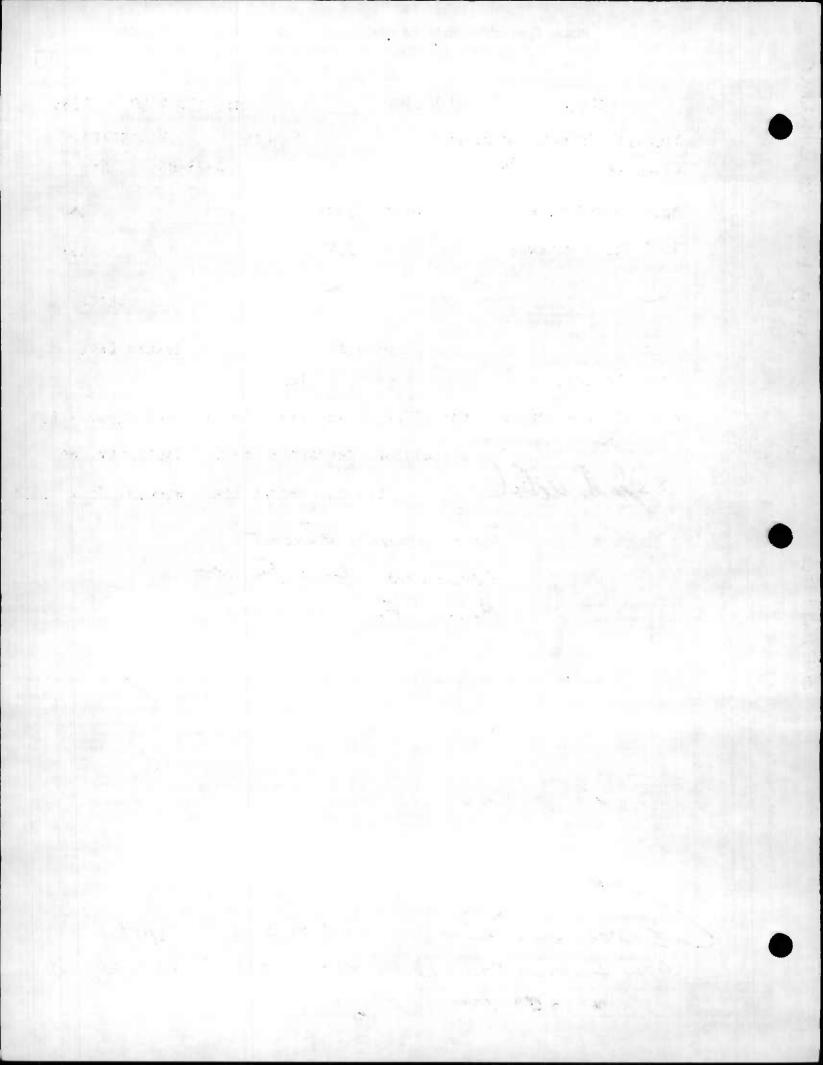
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW NOWAKOWSKI MP

125 N. MAIN ST. DEZHIR, MOZIO14

31. Date filed (Month, Day Year) 5 2000 32. Projetrar's Signetura

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	19a. Informant's N	Name/Relationship (7	ype, Print)			1			Rural Route Number			
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		sposition Cramation 3 5 Other (Specify		C	cemetery,	, cremate	on (Name of ory or other p aven C	emetery	Date 5/20/00	20c. Location -		
		uneral Service Licen						fress of Facility			-	
	10	undra son .	1			373	allio and	7 0 11.	-	1 Homo	Inc.	
	7 ~		Annalles						ns Funera	_		
	23a. Part1. Enter t shock, or hea	the disease, or comp art failure. List only	olications that caused one cause on each lin	i the deati	h. Do no	50	0 Univ	ersity B	1vd, W, S	ilver S		Approximate for the rot Between
	23a. Part1. Enter t shock, or hea Immediate Ceuse disaase or condition resulting in death)	art failure. List only o (Final on	olications that caused one cause on each line.	ne.	ATI	500 ot enter t	O Univ	ersity B lying, such as cerd	1vd, W, S liac or respiratory a	Silver S	pring	g, MD 209
iner	shock, or hea	art failure. List only o (Final on	one cause on each lir	ne. 7 5 7 7 Due to (o	ATI	500 ot enter t	O Univ	ersity B lying, such as cerd	1vd, W, S liac or respiratory a	Silver S	pring	Approximate Intervet Between Onset and Death
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32. Registrar's Signature

2000

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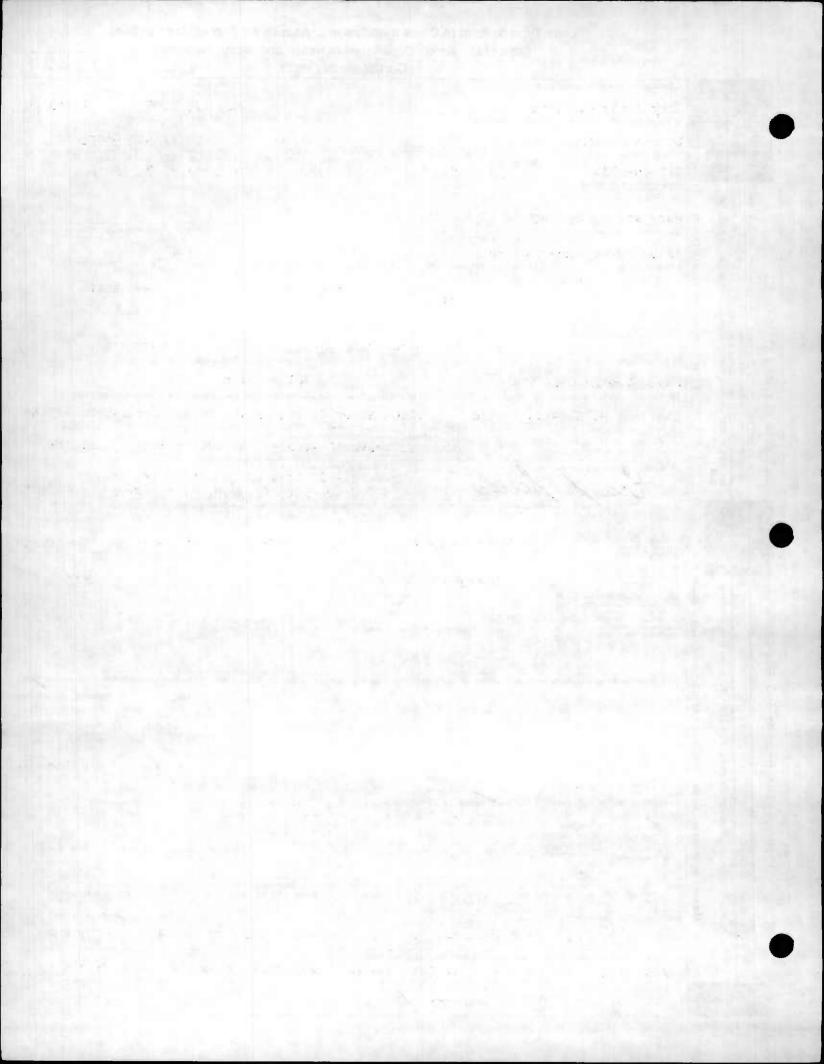
State Registrar

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



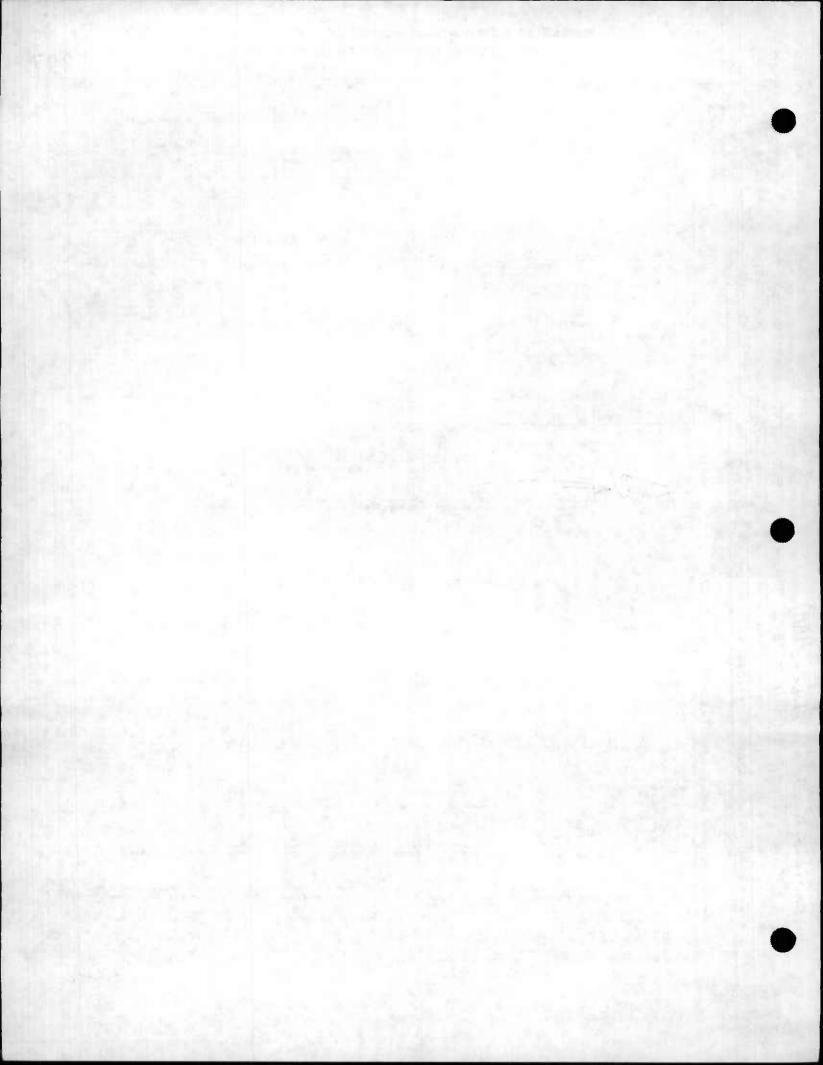
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** BERNICE GOLD 4c. County of Death MONTGOMERY /Medical 4s Facility Name (If not institution, give street and number)
SUBURBAN HOSPITAL 4b. City, Town, or Local BETHESDA Examiner If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth JUMOnth. (Oay, Year) 4 Birthplace (State or Foreign Country) MO **Funeral** Days 1□M 20 F Months Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY MD ROCKVILLE 1 No Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Funeral UNITED STATES

14. Raca - American Indian,
Black, White, etc. 11400 STRAND DRIVE #307 20852 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 ☒ No Specify: WHITE Specify: by 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) HOME MAKER 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 18. Mothar's Name (First, Middle, Maiden Sumame) SARAH (UNASCERTAINABLE) 17. Father's Name (First, Middle, Last)
MORRIS LANDIS 10 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) WALTER GOLD (SON) 11310 HOLLOW STONE DRIVE N. BETHESDA MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 5/15/00 1X Burlal 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) KING DAVID MEMORIAL GARDENS FALLS CHURCH VA 21. Signature of Fundal S ervice Licensee DANZANSKYLGOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE MD 20852 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batwaan Onset and Death **Physician** /Medical Immediate Cause (Final Carde pulmonar disease or condition resulting in death) Examiner aliac aus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Dtd tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings evailable prior to completion of cause 24a. Was an autopsy Completed 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 28b. Time of 28c. tnjury at Work? After 1 PNetural 5 Panding investigation 1 Yes 2 No 2 Accident Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 \(\text{Homicide} \) To the Hospital within 24 hours To the Funeral 1 dertifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signad (Month, Day, Year) May, 12th, 2000 DO51714 ucleon 12 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JATINDER SEKHON Blud Kesearch Sent 102. Rock ville. 31. Dete filed (Month, Day, Year) 32. Degistrar's Signature State 15 Registrar

R. Gold

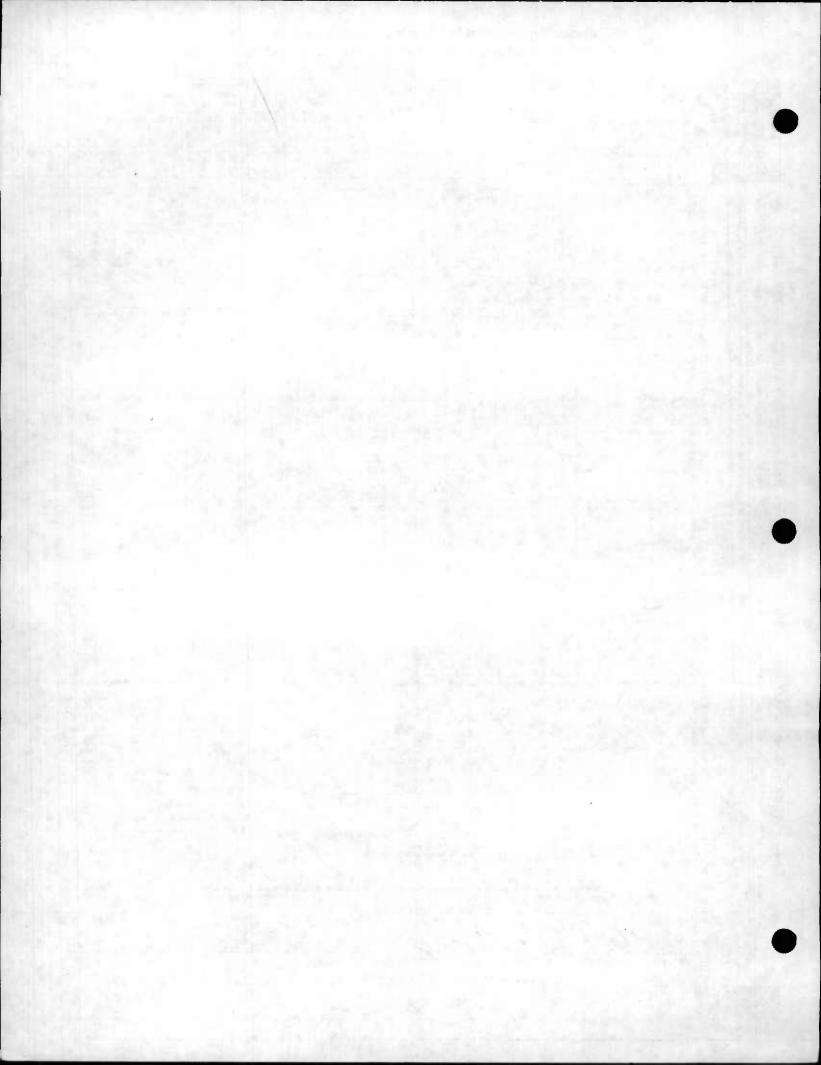
Berrice



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State of Maryland / Department of Health and Mental Hygiene 00 17298

				Cer	tificate o	f Death	7		Reg. No.	0	11620
	1. Decedent's Name (First, Middle,	Last)						2. Date of D	eath		3. Time of Death
Physician		Contra	do Chole	- C	1			Month	Day	Year	11.10 DV
/Medical	4a Facilità Nama (Mastinationi		de Shelto	on Go		4h City T	oum or Le	May 13 ocation of Dea		and Death	11:10 PM
Examiner	4e Facility Neme (If not institution,		iber)					ocation of Dea			
	Manor Care-Potom					Potom				gomer	J
Funeral	5. Social Security Number	5. Sex 7 1 ☐ M 2 ☑ F	7. Age (In yrs. last b		Months Day		r 24 Hrs. Min.	8. Date of B (Month, D	irth lay, Year)	9. Birth	place (State or Foreign ntry)
Director	577-48-7243 Usual Residence of Decedent	ILIM 200 F	84	Yrs.					ry 6, 1916		nnessee
natural, or items 23a or 28a-f show dical Examiner must be notified at sted by Funeral Director	10a. State 10b. County		10c. City, To	wn or Lo	cation						IOd. fnside City Limits
-	27/2	A1 / 7			Mook	doctor	- D	0			1 X Yes 2 ☐ No
Examinat must be notified at Examinat must be notified at by Funeral Director	N/A 10e. Street and Number	N/A			10f. Zip Code	ingto	п, р.		10g. Citizen of	What Cour	ntn.2
0 80	Too. Sheet and Humber				Tor. Zip Gode				Tog. Calzeri of	Wildle Cour	intry :
E 123	4106 46	th Street				2001					tates
frar mat	11. Marital Status	12. Was Dece	dent Ever in U,S. ces?	13. V	Vas Decedent of Yes, specify Cu	f Hispanic O Jban, Mexica	rigin? (Span, Puerto	ecify Yes or N Rican, etc.)	o- 14. Ra	ca - Americk, White,	
F	1 Never Married 2 ☐ Marrie	d 1 Yes :	2K)No		□Yes 2KIN				Specif		
leted by	3 Widowed 4 Divorced	Year or Da	tes:		24214	o open,			Specii	Whi	ite
Completed	15. Decedent's	Education	16	a. Deced	lent's Usual Occ	upation			16b. Kind of B	lusiness/In	dustry
De	(Specify only highest Elementary/Secondary (0-12)	College (1-	Aor E I	lite. C	kind of work don OO NOT use reti	ie auring mo red)	st of work	ing			
5	Elementary/Secondary (0-12)	5+			Teach	or			Privat	- S S C	hools
	17. Father's Name (First, Middle, Li				Teach	7	er's Nami	e (First Middle	e, Maiden Sumai		110015
Be	, , , , , , , , , , , , , , , , , , , ,					101111011				,	
J.		s Lucas G		-					Terrell		
	19a. Informant's Name/Relationshi	p (Type, Print)	19	b. Mailin	g Address (Stre	et and Numb	ber or Run	al Route Num	ber, City or Town	, State, Zip	Code)
	Elizabeth Good W	olfson/Si	ster 10	2 Ba	y Point	Harbo	our P	oint P	leasant,	New .	Jersey 0874
6	20a. Method of Disposition		000000	of Dispos	sition (Name of natory or other p	laca)		Dete	20c. Location		
important: If them 27 is marke any injury or other traumetic.	1 Burial 2 Cremation 3		tate			.2007	1 M	lay	041		g, Maryla
	21. Signeture of Funeral Service Li		Gate	OI	Heaven	Iross of Easi	ib.	17,2000	Silver	Sprin	g, Maryla
	21. Signature of Autorial Service En	Carisoo //		Ro	bert A.	Pumpl	rey	Funera	1 Home/		nsin Avenu
	X lens 7 h	eshet	M00335	Be	thesda.	Marv]	land	20814-	3501 "	1SCO	nsın Avenu
	23a. Part1. Enter the disease, or c	omplications that ca	used the death. Do	not ente	er the mode of d	ying, such a	s cardiac	or respiretory	arrest,		Approximate
n	shock, or heart failure. Cist or	nly one cause on ea	ich line.								Interval Between Onset and Death
	fmmediate Ceuse (Final		100		2522						
	disease or condition resulting in death)	a. Conge	estive He	art	Failure						Years
			Due to (or as a								
- ei		Athen	rosclerot	ic V	ascular	Disea	ase			1	Years
Examiner	Sequentially list conditions, if eny, leading to immediate		Due to (or as a	conseq	uence of):						
	cause. Enter Underlying Cause (Disease or injury										
edical	that initiated events	c	Due to (or es e	consequ	uence of):						
ledical Examir	resulting in deeth) Last									i	
2		d									
Physician	Part II. Other significant condition	s contributing to dea	ath but not resulting	in the ur	deriving cause	given in Part	1	23b Dt/	I tobacco usa co	ontribute t	o the cause of death
N/S	- a.t.ii. Garer argumoant condition	- sommouning to det	out not resulting	ar are ur	loonying cause	given in Fall					
	Dementia							10	Yes 2 No	3 Pro	bebly 4 Unknow
l by								04. 100		245 14	lere autonou findicas
Completed									s an autopsy lormed?	81	rere autopsy findings vailable prior to empletion of cause
ple								101			death?
Eo								10	Yes 2⊠No	1	□Yes 2□ No
	25. Was case referred to medical					os Die	na of Dact				
o Be	examiner?	Hospital:				Other:		h (Check only		The section	
-	1 Yes 2X No 27. Manner of Death	1 L In	patient 2 ER/C		1 3LI DOA	4 <u>X</u> J N	tursing Ho		sidence 6 Ot		(עד
6	1 Natural 5 Pending	28a. Date of (Month	o, Day Year)	Time of Injury	28c. In			280. Describe	how injury occu	rred	
ati	2 ☐ Accident investiga				M 1	Yes 2] No				
Ĕ	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica 28f. L								(Street and Num	ber or Rur	al Route Number,
building, etc. (Specify)							0	J. 111, G. 12. G.			
									e cause(s) and m	anner as s	stated.
edical	(Check only 2 Medical Ex	caminer: On the bas and mann		ind/or inv	restigation, in my	y opinion, de	ath occur	red at the time	, date and place	, and due t	o the cause(s)
Medical Certi	29b. Signature and title of certifier	21	0. 0		29c. Lice	nse number			29d. Date sign	ed (Month,	Day, Year)
7	1 Mint	. 1111 5	2.(11								
	, lucia	04/0	1 Com			D 38	781		May	15,	2000
	30. Name and address of person w	no completed cause	of deeth (Item 23a)) (Type, 1	Print)						
	Michael J. Grady	, M.D. 49	10 Massac	chuse	etts Ave	enue N	.W. #	#210 Wa	shingto	n, D.	C. 20016
State	31. Date filed (Month, Day, Year)	32. Rg	gistrer's Signature	,							
gistrar	MAY 17	2000	eneva	19	Spark	1					



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			no (Eiret A)					-	ooranoato or boati.	Reg. No.		-	Time of De
MEND	ITEMS:	#23	PART	I,	27,	PER	MEO	G784	Department of Health and Certificate of Death	Dog No.	00		163
ntoi	nette G	reen			S	tate o	f Mar	vland /	Department of Health and	Mental Hygiene	nn		729

sician	Decedent's Nar	me (First, Middle,	Last)		30				2. Date of Month	Death Day	v	Year	3. Time of Death
edical -	Mari	ia An	toinette	e Gre	een				Ma			000	05:18 A.M
			give street and numi					4b. City, Town	, or Location of De	ath 4c.	. County o	of Death	
			uth Laure			If Under	r 1 Vans	La La	aurel	F	Princ		orge's
	5. Social Security 216-96- Usual Residence of	-0008	Sex 7	Age (In yrs. 25	Yrs.	Months		Hours	Hrs. 8. Date of (Month, Oct.)	Day, Year)	74	9. Birtho Coun Ma	laca (Stata or Foreign try) ryland
-	10a. State	10b. County		10c. Cit	y, Town or Lo	cation						11	0d. Inside City Limits
to	MD	Pr.	Geo.		Laur	cel							1 ☐ Yas 2 ☐ No
Directo	10e. Street and Nu	umber				10f. Zip	Code			10g. Cit	tizen of W	hat Coun	try?
	1169	94 S. L	aurel Dr	cive,	#1C		2	20708	U.S.A.				
		ried 2 Marrie	If Yes, Give	es? 2000		Was Deced If Yes, spec 1 ☐ Yes		lispanic Origir an, Mexican, F Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	Black	- Americ k, White, Bla	
	3 LJ Widowed	4 Divorced	Year or Dat	es:	16a Daga	doet's Heur	al Occur	ation			fuetna		
		15. Decedant's acify only highest	grade completed)		16a. Dece (Give lifa.	kind of wo	ork done	during most o	16b. Kind of Business/Inc		ruony		
	Elemantary/Sec 12th		College (1-	For 5+)		eache				Da	y Ca	are	Center
T	17. Fathar's Name	(First, Middle, La	st)		18. Mother's				Name (First, Mid				
Anthony L. (19a. Informant's Name/Relationst Shirley L. S	ny L. G	reen		Sh			Shi	rley L.	Smi	th			
	Name/Relationshi	(Type, Print)		19b. Mailir	ng Addrass	s (Street	and Number	or Rural Route Nu	nber, City o	or Town, S	Stata, Zip	Code)	
	mith (Mo	other)	1169	94 S.	. La	aurel	Dr., #1	C, L	aure	el,	MD 20708		
Shirley L. S 20a. Method of Disposition 1 St Burlal 2 Cremation 4 Donation 5 Other (Sp		□Removal from St	tate	Place of Disponentery, created Nat.	natory or o	other pla		5/18/0		ocation - 0			
	23a. Part1. Enter shock, or he	the disaase, or coart failure. List or	emplications that car	used the deat	h. Do not ent	ROCE	KVII	LE, M	ID 2085	0			Approximata Intarval Between
ten ten disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		ion	a	MORB	ID OBE	SITY		ng, such as ca	ardiac or respirator	y arrest,			Onset and Death
	disease or conditi resulting In death)	onditions	a	MORB	ID OBE	SITY quence of):		ng, such as ca	ardiac or respirator	y arrest,		1	Onset and Death
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and address of person who completed ceuse of death (Item 23a) (Type, Print)

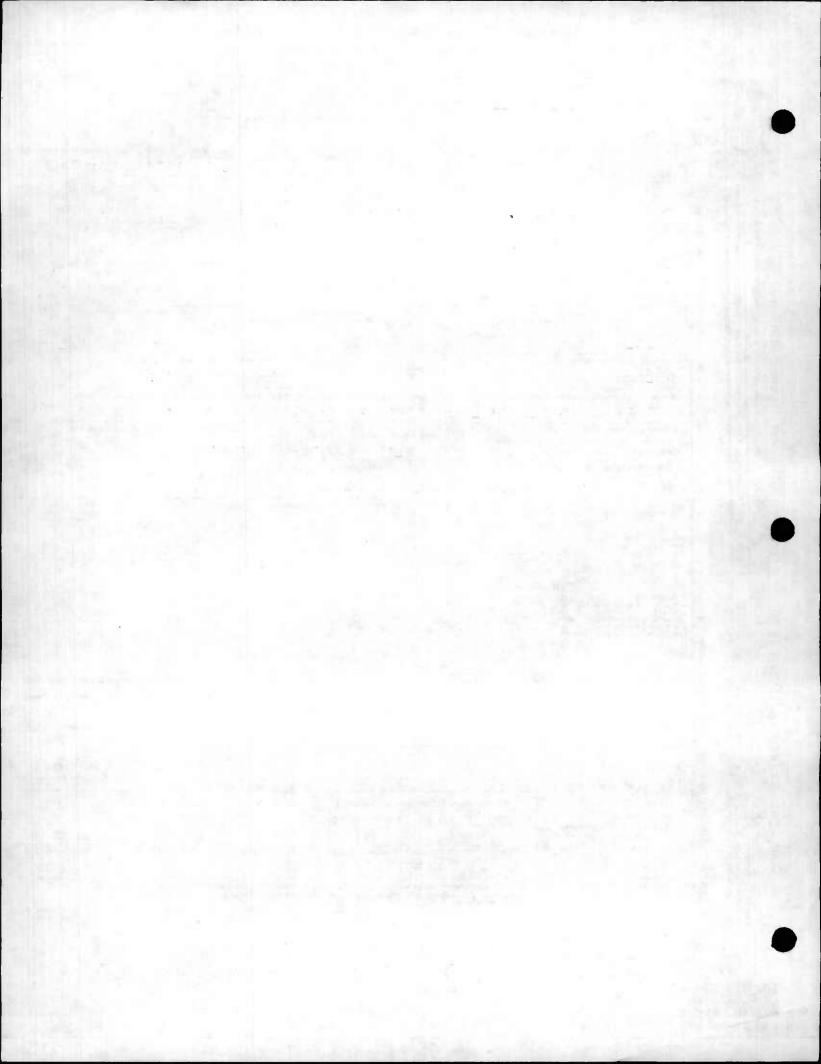
May 14, 2000

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

State Registrar

31. Date filed (Month, Day, Year)
MAY 18 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMENDED ITEM #23a PER MD G784 6/14/00 AH

AMENDED ITEM #23a PER MD G783 5/31/2000 AH

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month M A Y **Physician** Henry Roy HARDING 2000 8:25 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SHORE NURSING & REHABILITATION CTR. DENTON CAROLINE If Under 1 Yeer Months Deys 5. Sociel Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Dec. 3, 1909 7. Age (In yrs. lest birthday) 9. Birthptece (State or Foreign Country) Virginia **Funeral** 1 X M 2 □ F Deys 577-07-6504 90 Hours Director Usual Residence of Decedent 10a. Stete permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits MD Caroline Denton Director 1 XYes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 420 Colonial Drive 21629 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Mechanic Metro Bus 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be George Henry Harding Janie Bowles 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Stanley L. Harding 16893 Lentz Rd Henderson, MD 21640 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from State Painter Family Cemetery 5/6/00 4 ☐ Donetion 5 ☐ Other (Specify) Stanley, VA 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Bradley Funeral Home Moddel 187 E. Main St. Luray, VA 21a Part I Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, thock, or heart feilure. List only one ceuse on each line. Approximete tntervel Between Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Mailical ASPIRATION PNEUMONIA Examine Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest for use as the buriel-tran Due to (or es e consequence of) Records, P.O. Box 68760, Due to (or es e consequence of) Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. deteched 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings eveileble prior to Completed 24e. Wes en eutopsy performed? peed completion of cause of deeth? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this s efter death.
If Director: After this
od in by the funeral d 28c. Injury at Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Naturet Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Division of Vital To the Hospital
within 24 hours e
To the Funeral C Hospital

> State Registrar

Medical

31. Dete filed (Month, Day, Year) MAY 03 2000

Doffrey

29b. Signeture and title of cediff

4 Homicide

(Check only one)

29a. Certifier

32. Registrar's Signature

MS

30. Name end address of person who completed ceuse of deeth (ttem 23e) (Type, Print)

DO BOX

12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

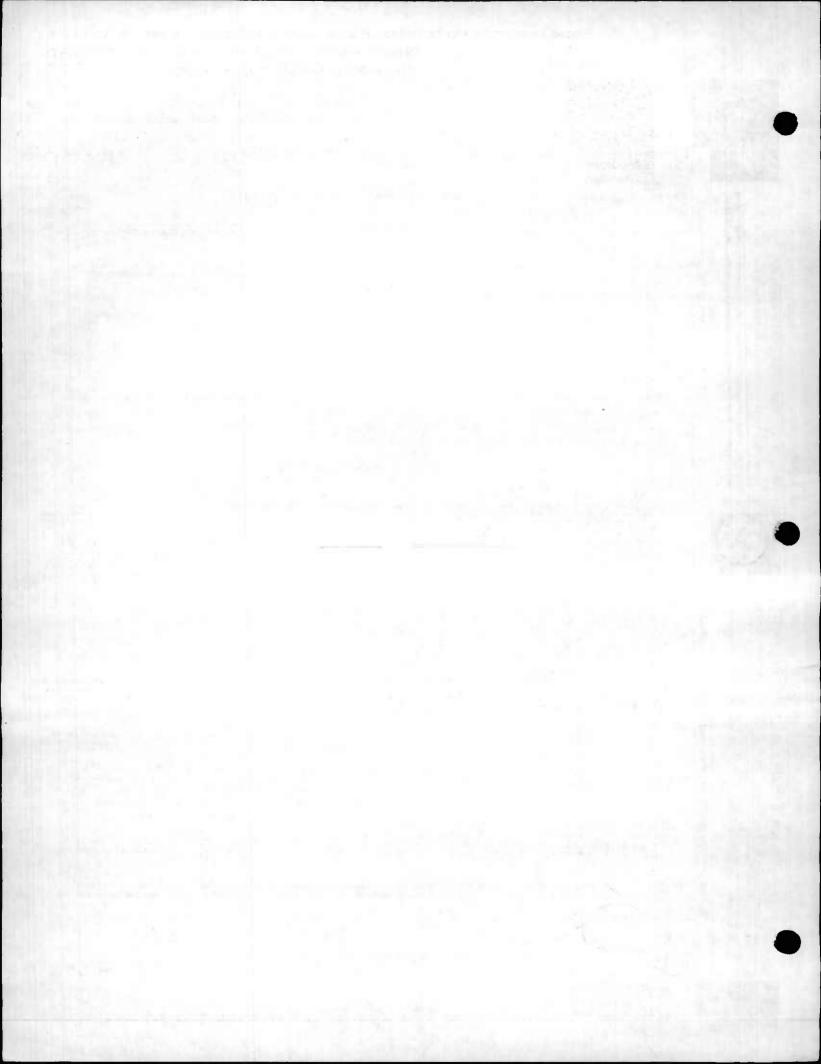
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29d. Dete signed (Month, Dey, Year)

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Goldstoro MD



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State of Maryland / Department of Health and Mental Hygiene 17201

			Certif	icate of			eg. No.	1/301
Physician	Decedent's Name (First, Middle, Las					2. Data of Deat Month		3. Time of Deeth
/Medical	Peggy Ann Hol					May	17 20	
Examiner	4a Facility Nama (If not institution, give	street and number)			4b. City, Town, or Lo		4c. County of	
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Funeral Director	3/9-30-34/0	7. Age (In yrs. 71 71 71 71 71 71 71 71 71 71 71 71 71		Under 1 Year onths Deys	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 2	2,1928	Birthpleca (State or Foreign Country) Wash., D.C.
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h with the Ma 3a or 28a-f a 1be notified al Director	10e. Street and Number 124 Groh Lane		1	2 140	3	1	0g. Citizen of Wh USA	
72 hours after death with the Maryland natural; or Items 23a or 28e-f show after Examinat must be notified at sted by Funeral Director	11. Marital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedant Evar in U Armed Forces? 1 ☐ Yes 2☐ No If Yes, GiveA Yaer or Detes:		Decedent of Has, specify Cub	Hispenic Origin? (Sp en, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		American Indien, Whita, etc. White
natural"	15. Decedent's Ed (Specify only highest gra-	ucation	16e. Decedent	's Usual Occup	petion during most of work	ina	16b. Kind of Busin	
withir than	Elementery/Secondary (0-12)	College (1-4or 5+)		NOT use retire lemaker	during most of work d)		e	
在工事 8	17. Father's Nema (First, Middle, Last)		1	-	18. Mother's Nam	e (First, Middle, I	Ma <i>idan Sum</i> ema)	
Mental H mrked off arked off	Claude W. Markwar	-d				ina Walk	er	
should la marke aurmatic	19e. Informent's Name/Reletionship (7		19b. Mailing A	ddrass (Street	and Number or Rur		-	ete, Zip Code)
45 et	Joseph M. Holley /			oh Lane		olis, MD		
of H	20e. Method of Disposition 1	Removel from State	Plece of Disposition cametery, cremeter. Lincol	ory or other ple			20c. Location - Ci Brentwoo	
emit. Pages 1 an Jepartment of Heal mportant: If item 2 mportant or other mes.	21. Signature of Funarel Service Licen			ama end Addre	in at Facility			
permit. Page Department of Important: If any Injury or once.	P Bus	Vall			101			eral Home, Inc. is, MD. 2140.
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Examiner	resulting in death)	Due to (or as e consaquen	nca of):	010000	urcin	2mc	Smonth
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aw requi						24e. Wes e		24b. Were autopsy findings avsitable prior to completion of cause of death?
The In						1 U Y	es 20 No	1 ☐ Yes 2 ☐ No
certificata rector, pa	25. Wes case referred to medicat				26. Place of Deel	h (Check only or	ne)	
S S D	examiner?	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA Oti	her: 4 Nursing Ho	/	ence 8 Othar	(Specify)
ding Physin. After this funeral dition: Tetton:	27. Manner of Deeth 1 Netural 5 Pending	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju Wo		-	ow injury occurred	· · · · · · · · · · · · · · · · · · ·
tal or Attending Phrs after death. In Director: After the director is a property of the funeral certification: "Certification:"	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Pleca of Injury - At h building, etc. (Special	ome, ferm, straat,			28f. Location (S City or Tow		or Rural Route Number,
To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Medical Certific	29a. Certifier 1 Certifying Phy (Check only one)	end due to tha c red at tha time, d	rie to tha causa(s) and mannar as stated. ha time, data end plece, and dua to the ceuse(s)					
within To the comp	end mennar steled. 29b. Signature and titla of certifier DOS0756 29d. Dete signed (Month)							
	30. Name and address of person who con Patricia P. Jet		m 23e) (Type, Prir B Holly A		uite 100	Annapo 1	is, MD.	21401
State Registrar	31. Dete filed (Month, Day, Year) MAY 1 9 200	32. Pegistrar's Sign	eture \mathcal{J} .	Spark	N			

July 1. LAND

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 14 2000 1643 Ruth Elizabeth Harris

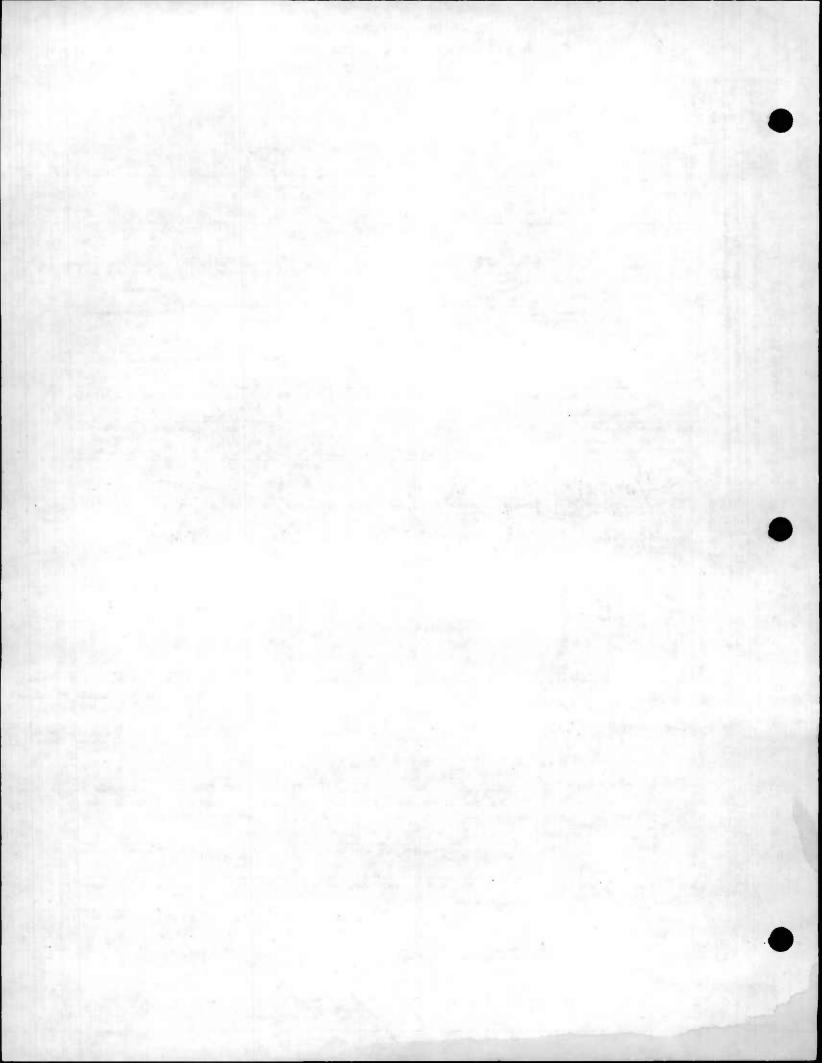
4e Facility Name (If not institution, give street end number) /Medical 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Harford Memorial Hospital Grace Harford If Under 1 Year 7. Age (In yrs. last birthday) 81 Yrs. 8. Dete of Birth (Month Pay Year) 5. Sociel Security Number 6. Sex Birthplaca (Stete or Foreign Country) **Funeral** 1 M 2 XF Director 165-12-7100 Elizabeth N.J Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Harford 1 ☐ Yes 2 No Completed by Funeral Director Aberdeen 10g. Citizen of Whet Country? 10s. Street and Number 10f. Zip Code 6 permit. Pages 1 and 2 should be filed within 72 hours-after death with Department of Heelin and Mental Hydens.

Superment if Item 27 is marked other than "natural", or flame 23a or many injury or other traumatic event, the secious Exercities mantale. 13 Poplar Grove Ave. U.S.A. 21001 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 M No If Yes, Give X Yeer or Detes: 1 Never Merried 2 Married 21215-0020 1□ Yes 20 No Specify Specifi@hite 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 Baltimore, Maryland 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) John B. Dane Grace Fredericks 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Marjorie Meritis 13 Poplar Grove Ave. Aberdeen, MD 21001 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Washington CR. 5/18/2000 Laurel, Md 22. Name and Address of Facility Witzke Funeral Home 1630 Edmondson Avenue Catons The sused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and hine. 1630 Edmondson Avenue Catonsville, MD 21228 Approximate Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of) Physician/Medical Examiner ettanding physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No After this certificate Division of Vital 25. Wes case referred to medical examiner? or Attending Physicien: funeral director. Be 26. Place of Deeth (Check only one) 1 □ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 1 Meturel 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, tectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier (Check only one) \$ 29b. Signeture and title, of certifie 29d Dete signed (Month, Day, Year) 0 30. Neme and address of pe cause of deeth (Item 23a) (Type, Pript) 31. Date tiled (Month, Dey, Year) 32. Registrar's Signeture State 9 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Mary B. Henaghan May 15, 2000 01:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Allegany **57 Mount Pleasant Street** Frostburg If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 20 F Yrs. 215-03-4297 Director 11-Dec-08 Maryland Usual Residence of Decedent 10a. Slete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 No Director Maryland Allegany Frostburg the Medical Examiner must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **57 Mount Pleasant Street** Name 23a 21532-U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MUNo If Yes. Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 "natural", or 1□ Yes 20 No If Yes, Give Yaar or Datas: Specify: Specify White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) owner/operator confectionery shop 8 permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: If New 27 is marked other any Injury or other traumatic event obtes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Sarah Harris 10 Reese Bevan 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Joanne Edwards Sister 61 Mount Pleasant Street Frostburg Maryland 21532-20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from Stete Frostburg Memorial Park 18-May-00 Frostburg, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Liceni 22. Neme end Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 nu wis 23a Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, lock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical DISEASE ORONARY ARTERY 3045 Examiner Due to (or as a consequence of): Examiner HYPERTENSION 30 ym ettending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): HypEn Upsdema P.O. Box 68760, 30 413 Physician/Medical Dua to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 1 Yes 2 No 3 Probably 4 Onknown Records. þ Completed 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? s certificate has b 2 NO 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificaletely filled in by the funeral director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of 1 Neturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifian edical completely (Check only one) To the within 2 29b. Signetura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) meelo coquer 5 10-0013166 16 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) nes Angel H. Roque, M.D., 48 Tam Terrace, Frostburg, Maryland 21532 31. Date filed (Month, Dey, Year)
MAY 1 7 2000 32. Registrer's Signature State Registrar

Mary B. Henaghan				MC	oy 15, 2000	/A C = 0
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Maryland Allegany	any	Frostburg				
57 Mount Plea	unt Pieasant St	reet 21532-	- 9		U.S.A.	
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8		owner/operator	10		it verbitiet ico	99
Reese Bevan			Sarah F	Homs		
Joanne Edwards Sae	Het 13	ic call from to	francis e	Hostburg	Maryland	21532-
		Frostoving Memorial Park		18-May-00	Frostburg, Mary	yland
		Duid Funer	emol Home	57 East Ave	Frostburg MD	21.32

Argel it. Roque, M.D., 48 fam Terrace, trostbing, Maryland 21532

MAY ; 7 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17304 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05/07/00 Pay Lakein Maurice Hall 1:12 A.M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number If Under 1 Months 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F Hours 216-15-2658 19 04/14/81 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Worcester Pocomoke 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country?

21851

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes 2 ☒ No

None

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

USA

None

May 7, 2000

18. Mother's Name (First, Middle, Malden Surname)

14. Race - American Indien. Black, White, etc.

Specify: Black

16b. Kind of Business/Industry

Physician /Medical Examiner

Physician

/Medicat

Examiner

10a. State

11. Marital Status

217 Market Street

1Never Married 2 ☐ Married

15. Decedent's Education (Specify only highest grade completed)

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12. Wes Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

Director

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show their yor other treumstic event, the Medical Examiner mast be notified at once.

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

requires that the death certificate be

Examiner attending physician and for use as the burnal-true been signed by the a should be detached t

To the Hospital or Attendi within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fo

State Registrar

deeth.

Physician/Medical ğ Completed Be 2 Certification: edicai

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

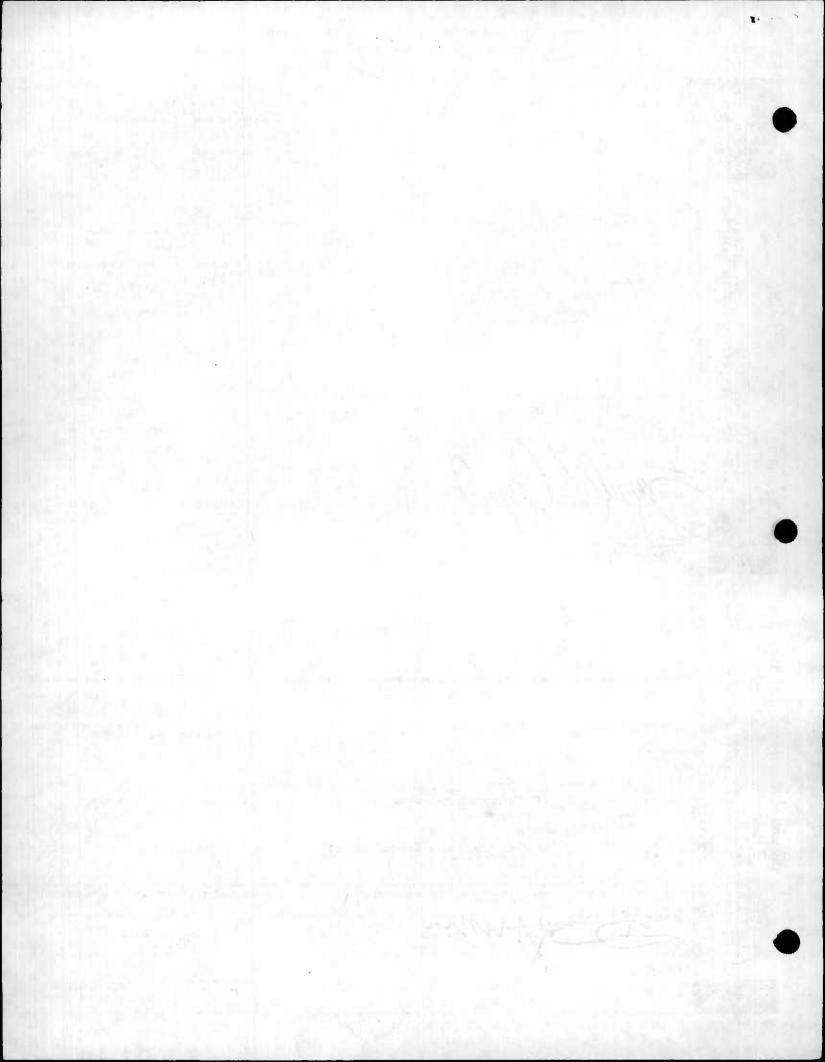
DANIEL R. MELDRUM, MD

31. Dete filed (Month, Day, Year)

128260

Be Alphonso Milbourne Gale Denise Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gale Denise Hall/Mother 217 Market Street, Pocomoke, MD 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Rem 4 Donetion 5 Other (Specify) Zion Indep. Meth. Cem. 5/13/00 Withams, VA 2. Name and Address of Facility
Cooper & Humbles Funeral Co., Inc.
December 176 Accomac, VA 23301 21. Signature of Funeral 22. Name and Address of Facility the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate Interval Between Onset and Deeth Immediet - Cause (Final disease or condition resulting In deeth) Pulmonary Edema 24 days Due to (or as e consequence of) Mitral Stenosis 5 years Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes ZONO 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 X Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)



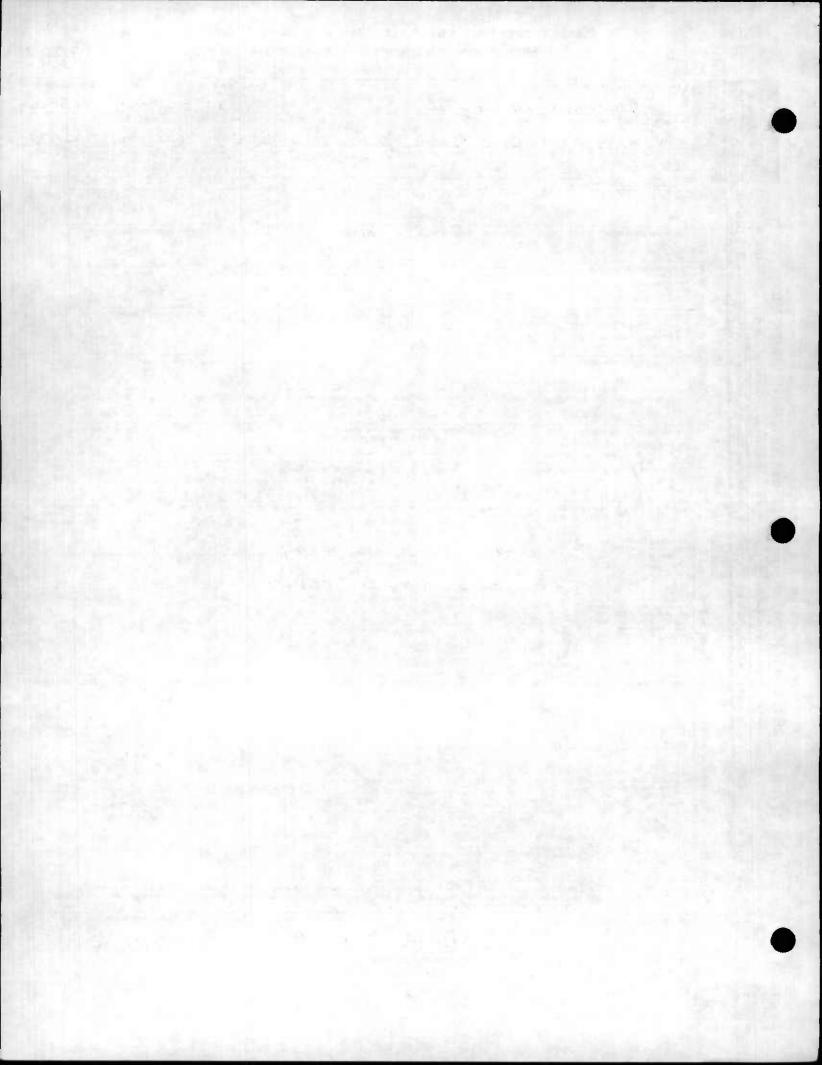
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State of Maryland / Department of Health and Mental Hygiene

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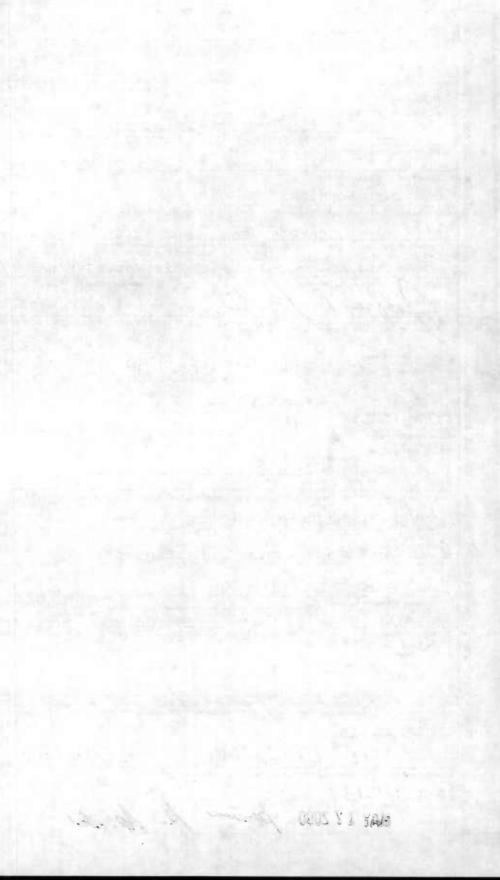
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Director	10e. Street and Num					10f. Zip					10g. Citizen of V	vhat Coun	itry?
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E	3 Suicida 4 Homicide	6 Could not be determined	20a. Place o	f Injury - At ho	ma, farm, st	reet, factor	y, office		28	of. Location (5		er or Rure	al Routa Number,
9	4 D Homicide		bullaing	, atc. (Specify	')					Only or Tor	m, olula)		
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	M	lanh.	NIC	2015	z mD		PI	340	/		5/	91	00
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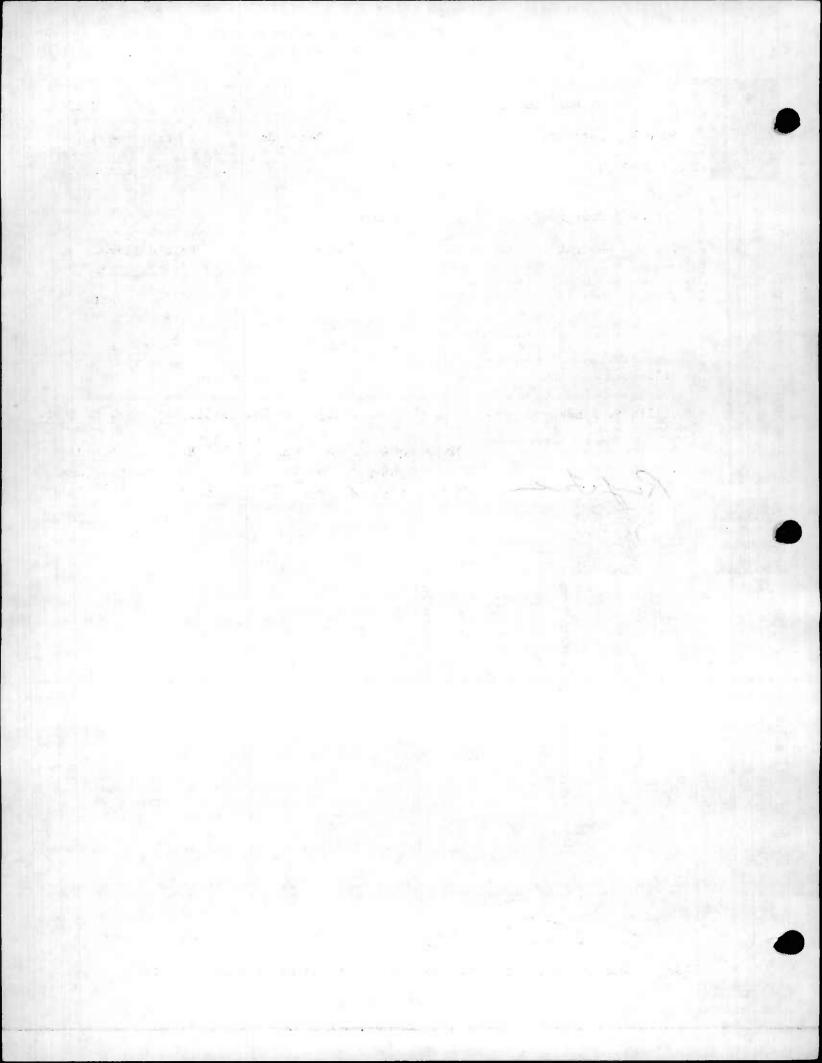
	Certificate of Death		Reg. No.	0 17300
Dhualaian	Decedent's Neme (First, Middle, Last)	2. Date of De Month		3. Time of Death
Physician Medical/		05	12 0	50 1650
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death	h 4c. County of	Death
	RAPowley ShockTraw A Center Balti	uve	Breett	Hore Cety
neral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Months Days Hours	Hrs. 8. Date of Bir Min. (Month, De	th av Year)	Birthplace (State or Poreign Country)
ctor	220-14-5906 To Price	7/20/		ennsylvania
4	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Funeral Director	MD Harford Street			1 ☐ Yes 2] No
2	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	net Country?
0	3747 Bay Road 21154	1. 1. 1.	United	States
Der	11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No		- American Indien,
by Fu	1 Never Married 2 Married 1 Total Street Str	uerto ricen, etc./	Specify:	, White, etc. White
			16b. Kind of Bus	
Completed	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	working		,
E	Elementary/Secondary (0-12) College (1-4or 5+) 11 Boiler Maker		Civi1	Service
CO	17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle,	1	
o Be	Banjamin Hopkins E11a	Woodrow	7	
F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number of			State Zin Code)
	20a Method of Disposition 20b, Place of Disposition (Name of	Square,	Bel Air	t, MD 21015 City or Town, State
	11 Burlal 2 □ Cremation 3 □ Removel from State cemetery, cremetory or other place)			
	4 Donation 5 Other (Specify) Bel Air Mem. Garden	s 5/16	Bel Air	r,MD
8	21. Signatum of Funeral Service Licensee 22. Name and Address of Facility			
	Leffley Forcles Harkins Funer	al Home,	Inc.,	Delta, PA
	239 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cel nock, or heart tailure. List only one cause on each line.	diac or respiratory e	errest,	Approximate Interval Between
n	The state of the s		-	Onset and Deeth
1	Immediate Cause (Final disease or condition resulting in death) a. Massive upper gas to intest	inal hla	ed wa	Mharas
	disease or condition resulting in death) Due to (or as a consequence of):	THE CO	A	Thurs.
Jer			V	Challa
Ē	Sequentially list conditions b. Due to (or es a consequence of):			172775
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury cause (Diseas	+10-	10	Huranta
		1 legau	ed Perme	am Tweens
edicai	resulting in death) Last Due to (or as a consequence of):			
Z				
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Completed by Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.	23b. Dld	/	tributs to the cause of death?
F	(Level to my opathy	10	Yes 2 No	3 Probably 4 Unknown
by				A4 14 P. P
ted	ENDSTAGE RENAL DISEASE	24a. Was	an autopsy ormed?	24b. Were autopsy findings available prior to
ple				completion of cause of death?
PO	Diabetes Mellitrus	10	Yes 2 No	1 ☐ Yes 2 ☐ No
Be C	25. Was case reterred to medical 26. Place of	Deeth (Check only	one)	
ToB	axaminer? 1 Yes 2 No Hospital: 1 Lippatient 2 ER/Outpatient 3 DOA Other: 4 Nursi	ng Home 5 🗆 Resi		r (Specify)
L :: L	27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?		how injury occurre	
Certification:	1 Netural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident Investigation M 1 □ Yes 2 □ No			
fice	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office	28f. Location (Street and Numbe	r or Rural Route Number,
ert	4 Homlcide building, etc. (Specify)	City or To	wn, Stete)	
		lace and due to the	cause(s) and men	ner as stated
Medical	(Check only 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death one)			
×	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Dey, Year)
	A CALLA CALLA	16	0 - /. ~	100
	Orlaign Meny Mrs. 125167	T	05/12	-100
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1/	05.	1 01001
	SHACONTENEYUM 765. GREEDEST. DI	ALTIMO	NO M	0 21201
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	MAY MILLION CONTRACTOR			



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Physic		1. Decedent's Name (First, Mid	dle, Last)	5 5			rtificat			2. Dete of D			W	3. Time of Deeth
/Medi		M	laurice D.	Han	degar	d				Month May	11	оеу • 20	Yeer	9:25 AM
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		Suburban Hosp	ital						Bethesd	a		Mont	gomer	У
Funerai Director		5. Sociel Security Number 473-09-7724	6. Sex 1 M 2 □ F	7. Age	(In yrs. les	t birthdey) Yrs.	If Under Months	1 Yaar Deys	If Under 24 H Hours M		Birth Dey, Yea	917	9. Birthple Country Minn	ce (State or For y) esota
MOW III		Usuel Residence of Decedent 10e. Stete 10b. Coun	ty		10c. City, T	Town or Lo	cation						100	d. Inside City Li
28a-f si pulfied	Director		gomery			Betl	nesda							1 Yes 21
3a or		10e. Street and Number 9707 Old Georg	etown Roa	d #2	102		10f. Zip	Code 2081	4				Whet Country State:	•
if, or items 23s or 28s-f show common must be notified at	by Funeral	11. Marital Status 1 Never Merried 2 Me 3 Widowed 4 Divorce	12. Was De Armed F 1 XYes	ecedent Ev Forces? s 2 No	er in U,S.		Wes Deced if Yes, spec		lispenic Orlgin? en, Mexicen, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		14. Rac	e - Amaricai ck, White, et	n Indian, c.
"natural", or i	ted	15. Decede	ent's Education				dent's Usue	I Occup	ation during most of w	an elvin a	16b.	Kind of Bu	Whit uslness/Indu	
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marked o	To Be	Gilbert Hande	gard							Bjornsta				
is mar	-	19e. Informant's Name/Relation	ship (Typa, Print)			19b. Meilir	ng Address	(Street	end Number or	Rurel Route Num	ber, City	or Town,	Stete, Zip C	ode)
n 27 i		Lucille F. Han	degard/Wi	fe						Rd.,#210	2, I	Bethe	sda, 1	4D 2081
Deportment of reality of marked objections any Injury or other traumatic event, once.		20a. Method of Disposition 1 ☐ Buriel 2 ②Cremetion 4 ☐ Donetion 5 ☐ Other (n State			sition (Nem netory or of Cremat		m, Inc.	May 13, 2000			City or Town	ryland
Import any inj		21. Signature of Funeral Service	Licensae	м	00198	RC 75	Name and bert 57 Wi	Addre	ss of Facility Pumphre nsin Avi	y Funera enue d 20814				
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€ 5	Be	25. Wes cese referred to medical exeminer?	Hospital					011		eeth (Check only				
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0 0		1 ☑Naturei 5 ☐ Pendi	ng (Moi	nth, Day Y	- At home	Injury	M eat, fectory,		Yes 2 □ No	28f. Location	(Straet	and Numbe		Route Number,
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Director: After the in by the funeral	edical	2 Accident invest 3 Suicide 6 Could 4 Homicide deter	not be nined 28a. Plec build ng Phyelcian: To the Examiner: On the build	ding, etc. (ny knowlec	ige, deeth end/or inv	occurred e restigation,	t the tim	ne, date end ple pinion, deeth occ	ce, end due to the curred et the time	ceuse(s) end mei nd place, e	nner es stete end due to th	ed. e causa(s)
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 4b. City, Town, or Location of Death Year **Physician** Harris Beatrice M. 15 AUU 4:30 PM /Medical 4a Facility Neme (If not institution, give street and number) Examiner 1618 Glen Keith HUnder 24 Hrs. 8. Date of Birth (Month, Day, Year) Blvd. Balhmore If Under 1 Year 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20F Days 87 213-10-7412 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Wedical Examiner must be notified at Page. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Ralhmore Director Balhmore 10g. Citizen of What Country? 10f. Zip Code BLVd. 21286 1618 Glen Keith U.S. A by Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 (No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1□ Yes 2D No Specify: Specify: White 3 Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Switch Board Operator 18. Mother'a Neme (First, Middle, Maiden Surneme) 17. Father'a Neme (First, Middle, Last) Mary A. Phillips

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Cleveland Sigler 19a. Informent's Neme/Reletionship (Type, Print) 17314 20b. Place of Disposition (Name of cametery, crametory of other place) L Harris 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) Apatomic 61ft Foundation 5/15/00 Laurel MD 22. Name and Address of Facility
Anatomic Gift Foundation
139118 Pathmon Avenue Laure MD 20707 21. Signeture of Funerel Service Licensee 0 Approximate Interval Between Onset end Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Discuse Metastatle 3 month Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as e consequence of) P.O. P Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Convay Hatery Discuse Records, Completed by 24b. Were autopsy findings available prior to congertine head Failure 24a. Wes an eutopsy performed? completion of cause of death? MA 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medicat examiner?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Menner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 (PNaturel 5 Pending investigation 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) NA 1 Yes 2 No 2 Accident NOF 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide NA 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one)

State

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A. hoper

19 2000

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31. Dete filed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

LOPEZ IND

Registrar **DHMH 16 Rev 6/95**

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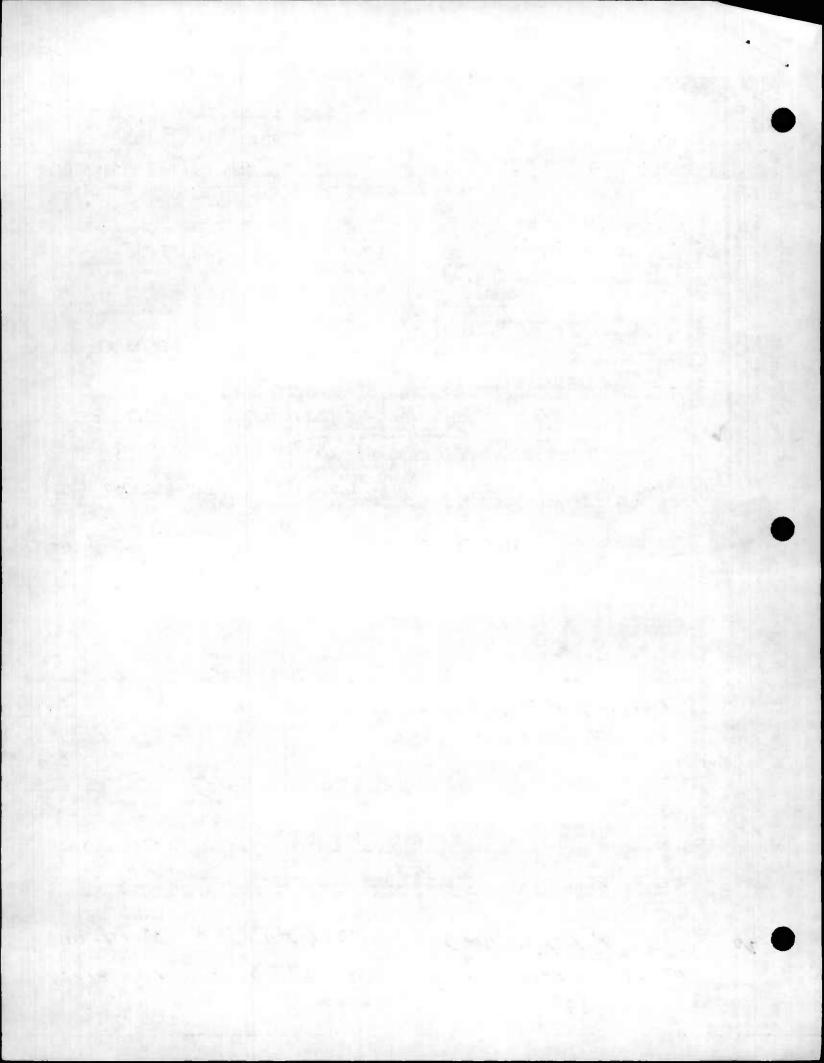
32. Registrar's Signature

8415

29c. License number

29d. Date signed (Month, Day, Year)

Bellone Lane Tonson Nick 21204



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month MA-7 Year RALPH G. HAUGHT 1001 COOL 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death MONTGOMENT BETHEROA BETTESOA WHUAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 6. Sex 1 M 2 □ F Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Months Deys Hours Yrs 76 Aug 11, 1923 Pennsylvania 193-16-5697 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Silver Spring Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20902 IISA 11514 Colt Terrace 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien 11. Maritel Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White WWII 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kInd of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Department of Defense Financial Analyst 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Lela Shepard Herbert Haught 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 11514 Colt Terrace, Silver Spring, MD 20902 se of Disposition (Name of Dete 20c. Location - City or Town, State Elizabeth Haught/ Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Arlington National Cemetery 2000 Arlington, VA 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Ken Stelle Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth SERSU 2º 70 SELF INTECTED SUBSTANCE Immediete Ceuse (Final diseese or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Due to (or es e consequence of) 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 2 No 3 Probably 4 Unknown ESOPHOOUS 24b. Were autopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy 1 Yes 2 □ No 1 ☐ Yes 2 No 25. Wes case referred to medical

Physician /Medical Examiner

certificate be

P.O.

Division of Vital Records,

Attending Physician:

ŏ Hospital

efter death. Director: Aft

To the I within 2

Physician

- /Medical

Examiner

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Funeral

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permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hyglene. Important: if Item 27 is marked other than "naturel", or items 23s or 28s-1 show an injury or other treumatic event, the Medical Examiner must be notified at page.

Maryland 21215-0020

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sicien end buriel-transit the 88 à signed be del page 2 certificate director this

Examiner Physician/Medical p Completed Be 2 funerel Certification: 8 24 hours efter Funeral Dire tetely filled in b

1 Yes 2 No

27. Manner of Deeth

1 Naturel

2 Accident

3 Sulcide

4 ☐ Homicide

31. Dete filed (Month, Day, Yeer)

CARCINOMA

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 28c. Injury et Work?

SOF DIFFERS WATER THE A CENTRAL

281. Location (Street and Number or Rurel Route Number, City or Town, State) 11514 COUT TOLLY STUDENT STUDENT

Modical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated.

2 Modical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifin (Checi one)

and title of certifier 29b. Signal CARL MARGOUS

MAY 1 7 2000

5 Pending

investigetion

6 Could not be determined

29c. License number

1 Yes

2 No

29d. Dete signed (Month, Dey, Year) MA7 13, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PIKE, ROCKIUS, NO 10852

State Registrar

completely

12

Medical

32. Registrer's Signature

Hospitel: 1 Unpatient 2 ER/Outpatient 3 DOA

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

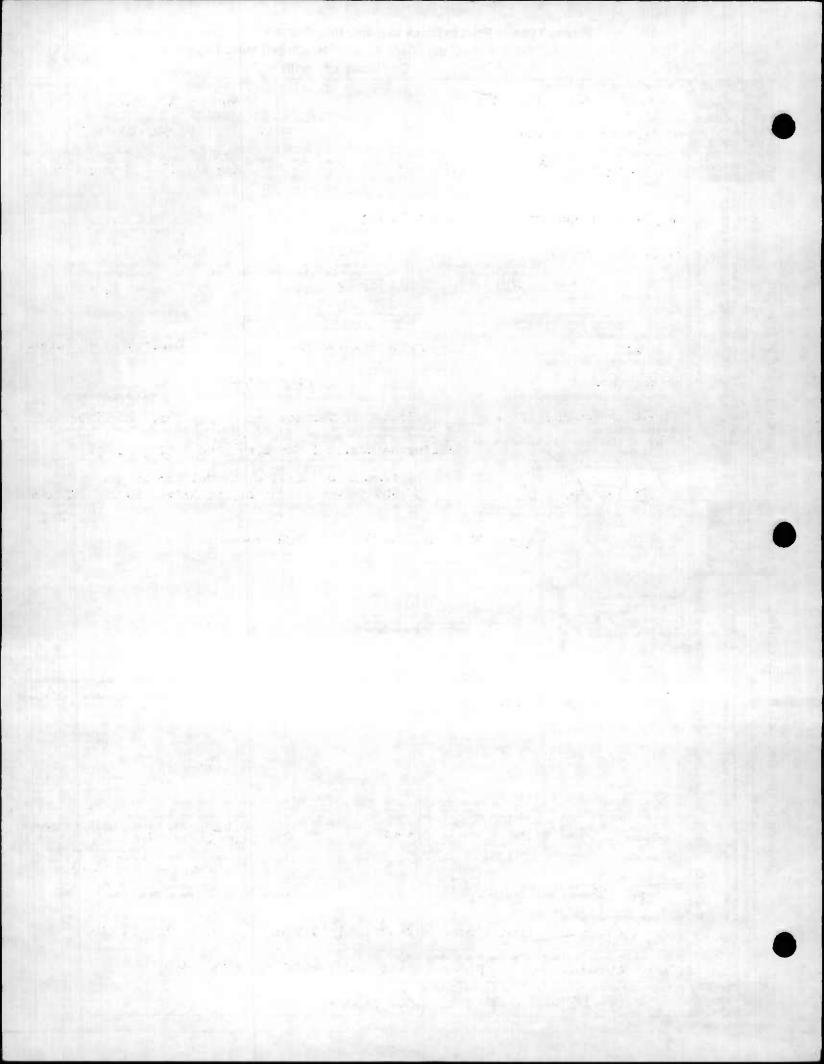
Injury

CHKHONNW

HOME

28a. Date of Injury (Month, Dey Year)

MAY 11, 2000

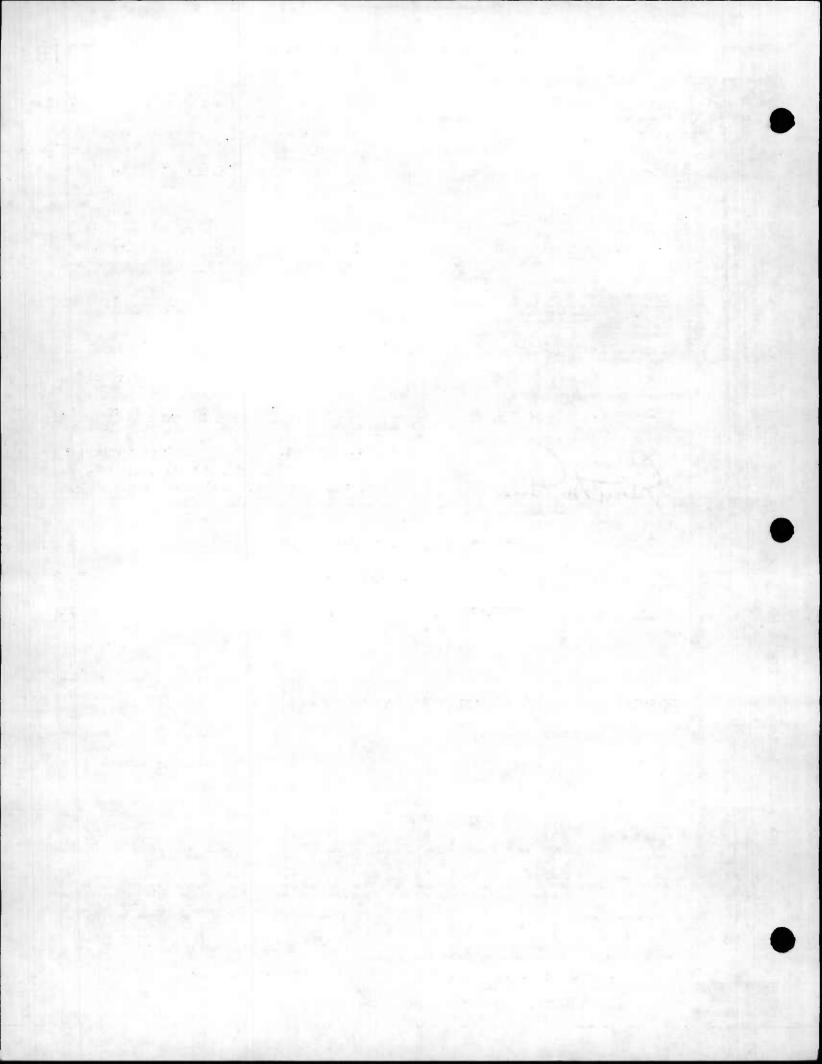


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State of Maryland / Department of Health and Mental Hygiene

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			(Certifica	te of	Death		Reg. No.	0 1/010
	1. Decedent's Neme (First, Middle, La	st)		-			2. Date of D	leath	3. Time of Death
Physician /Medical	Louise Ann Heffro	on					May 1	4, 2000	6:10am
Examiner	4e Facility Neme (If not institution, giv	e street and number)				4b. City, Tow	m, or Location of Dea		
	3576 Chiswick Cour	ct, #1C					Spring		gomery
Funeral Director	5. Social Security Number 6. S 577-56-0501	DM 2DE	(In yrs. last birth	Month	er 1 Year s Days		Min. (Month, L	Sirth (Nay, Year) 9, 1908	9. Birthplece (Stete or Foreign Country) Virginia
pu de m	10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
Many Heat	Maryland Montgome	erv	Silve:	r Spri	nø				1 Yes 2 No
r 28g	10e. Street and Number	-1,	DILVE.	-	ip Code			10g. Citizen of V	What Country?
th will	3576 Chiswick Cour	ct, #1C			20906	5		United	States
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Physiene. Important: if tam 27 is marked other than "natural", or theme 23s or 28e-f show any injury or other traumatic avant, the Medical Emriton must be notified and		12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:		If Yes, sp	ecify Cub	Hispanic Originan, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)		e - American Indien, ck, White, etc. White
5-0 72 ho	15. Decedent's Ed	ducation	16a. D	ecedent's Us	ual Occu	pation	of undring	16b. Kind of B	usiness/Industry
21215-0 ed within 72 ho ygiene. nor than "netur it, the Heafield Completed	(Specify only highest gra	College (1-4or 5-	1	ife. DO NOT	use retire	during most od)	or working		
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and be fill be	17. Father's Name (First, Middle, Last)						's Neme (First, Middl		
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1 and 1 and Health Health other tr	Ann Chapman, daug	ghter	20b. Placa of D	isposition (N	ame of		#1C Silve	T -	city or Town, State
Baltimore, wenti. Pages 1 an beartment of Heal mourtant: if Itam 2 ny Injury or other	1 Burial 2 Cremetion 3 4 Događijon 5 Other (Special		Gate of	He ave			May 18,		
Altir artmo ortan Injur	21. Signature of Fuperal Service Licer		Bate OI			ess of Facility	2000		Spring, MD
Balt Permit. Departminiports any inju	Hour to	Line					Devo	ol Funera hersburg	
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corc requir been s should							24a. Wa	s en autopsy formed?	24b. Were eutopsy findings availeble prior to completion of cause of death?
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of Vital Re Physicien: The I ribls certificate ha rial director, page	examiner? 1 Yes 2 No	Hospitel:	nt 2 ER/Outo	atient 3 1	DOA O	hor	sing Home 5⊠ Re		er (Specify)
g Physical desired des	27. Manner of Death	28a. Date of Injury (Month, Day	/ 28b. Tin		28c. Inju Wo			how injury occur	
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To the complex	29b. Signature and title of certifier			2	9c. Licen:	se number		29d. Date signe	d (Month, Dey, Year)
16	· Olman)	Cance	as her		D'	25410		May 15,	2000
	30. Name and address of person who	completed cause of de	ath (Item 23a) (To	rpe, Print)	D2	23410		ridy 13,	2000
	Oliver J. Lawless				lip I	Drive.	#126, 01r	ney, MD 2	20832
State	31. Date filed (Month, Day, Year)	32. Régistrai		. /	9	,			



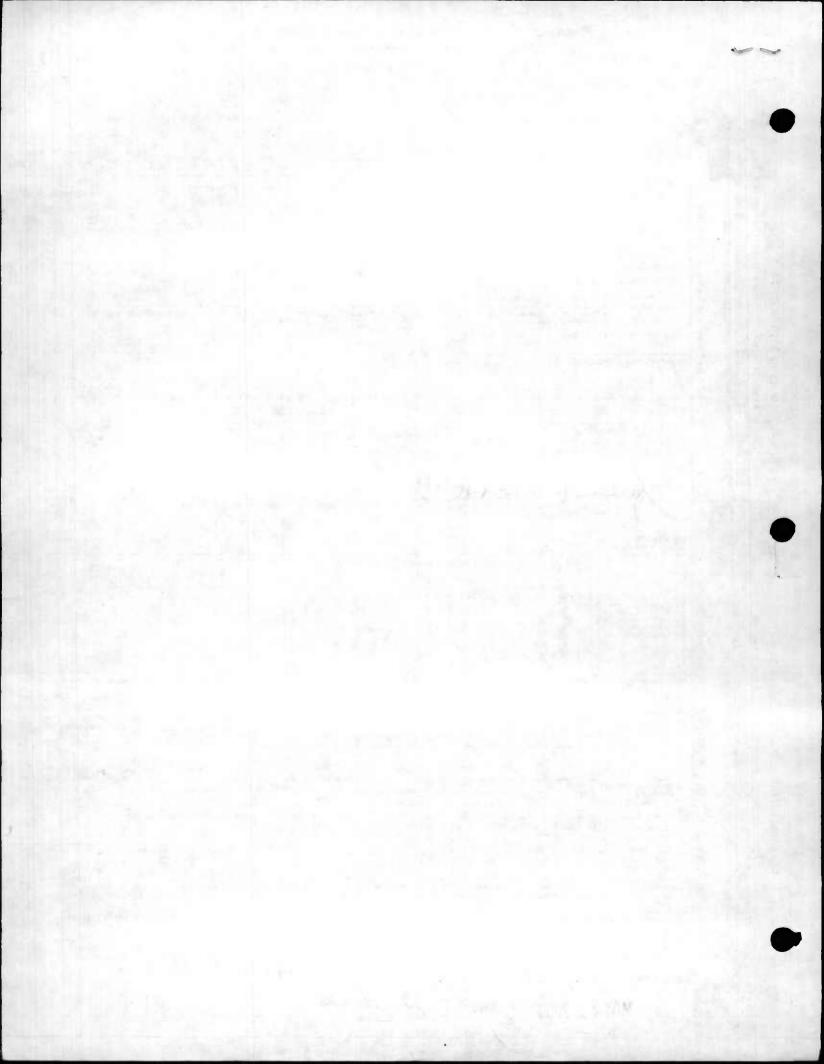
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Funeral Director		5. Social Security N 433-37-2		.Sex 1□M 2∏ F		29 Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di June	12, 1970	9. Birthplace (State or Foreig Country) Worth, T	'\
Maryland 4 ahow		Usual Residence of 10a. State MD	Decedent 10b. County Balti	more		ity, Town or Lo							10d. Inside City Limit	
after death with the Marylar or flerne 23e or 28e-f show miner must be notified at	runeral Director	10e. Street and Nun		geDriv	e #102	9	10f. Zip	Code)			10g. Citizen of USA	What Country?	
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pemit. Pag Department important: I any injury o page.		21. Signature/of Fu	neral Service Lic	censee	2190	20 22						uneral S lls Chui	Service, Inc. cch, VA 22046	
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	5	resulting in death)		8	Due to	or as a conseq	uence of):							
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ne Hospital or Attanding Ph n 24 hours after death. The Funeral Director: After th stelly filled in by the funeral	Togato.	27. Manner of Death 1 Netural 2 Accident 3 Suicide	5 Pending investigat 6 Could not determine	be 28e. Ple	te of Injury onth, Day Year) ce of Injury - At I	28b. Time of Injury	М		vai k? Yes 2□	No	28f. Location		per or Rurel Route Number,	
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To the Hospital within 24 hours a within 24 hours and the Funeral completely filled		Urie)	41	and ma	zilifoi atotoa.									

State Registrar

Dennis J. Chutens
31. Dete filed (Month, Day, Year) 32. Rg MAY 3 1 2000

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 2000 8:00 PM MAY Robert Н. Jones /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Saint Mary's Hospital St. Marv's Leonardtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Dey, Year)
March 31, 1925 Florida 7. Age (In yrs. last birthday) **Funeral** Days Hours DOM 20 F 75 Yrs. Director 262-22-3890 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Directo Maryland Anne Arundel a or 28a-f Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "... any injury or other traumatic... 1205 Holly Avenue 20764 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 12☐¥es 2☐No WWII If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White þ 3₺Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Artificial Limb Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Prothesis Technician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Sam H. Jones Corie E. Miller . 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Lenhart/Daughter same as item 10 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 5/20/2000 Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service by 22. Nama and Address of Fecility George P. Kalas Funeral Home, P.A. alre 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirelory errest shock, or heart failure. List only one cause on each lina. Approximete Interval Batween Onset and Deeth **Physician** Immediate Cause (Finef disease or condition resulting in death) /Medical ATheroscierotic CARDIOVACIAR discARD Examiner Due to (or es e consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Due to (or es a consequence of): Part fl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 □ Probably 4 N Unknown ٥ After this certificate has been signed funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes an eutopsy meetive He mi intune 1 Yas 2 No 1 Yas 2 No of Vital Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 2 Accident Division 5 Pending investigation To the Hospital or Attanding within 24 hours effer death. To the Funeral Director: Afte completely filled in by the fun. 1 Yas 2 No 6 Could not be detarmined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the tima, data and place, and dua to fine cause(s) and menner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MY 30. Name and address of person who completed bausa of death (frem 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

WILLIAM D. BOYD III M.D.

MAY 2 2 2000

31. Date filed (Month, Day, Year)

HARRISON JONES

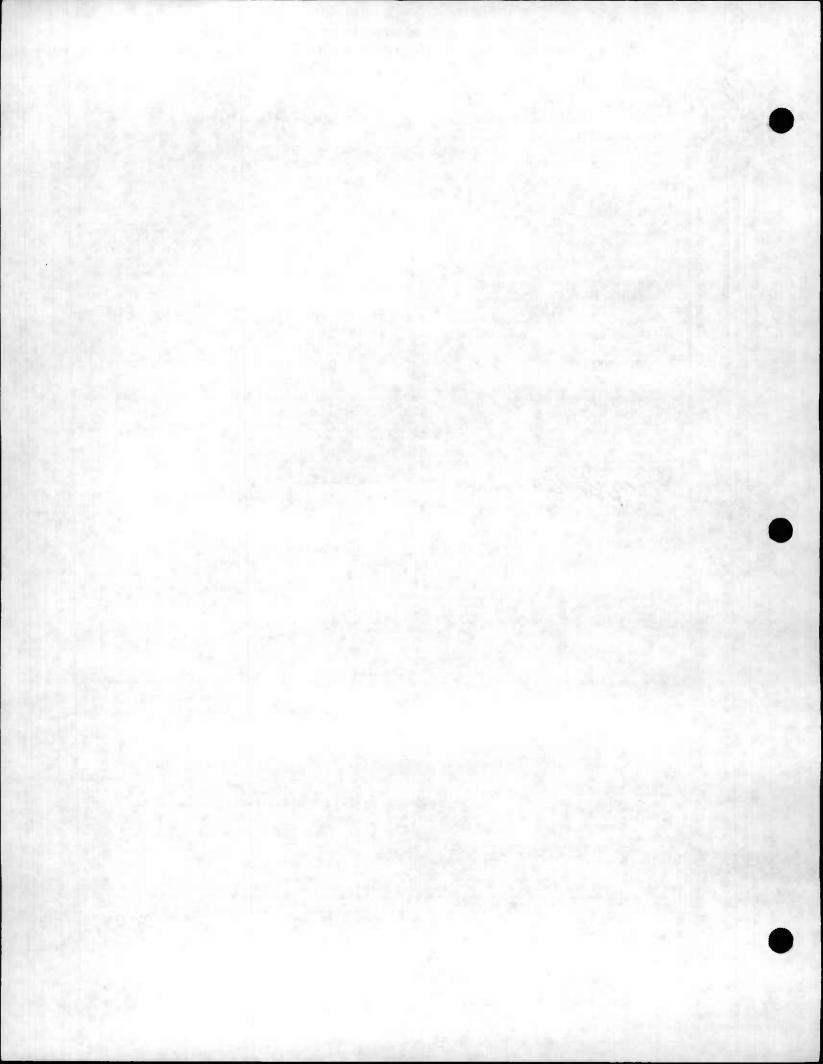
ROBERT

LEONARDTOWN:MD. 20650

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Helen Johnson May 8, 2000 12:10 am /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6020 Sargent Road Apt. 2105 Prince George Hyattsville If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2₩F 577-28-3019 78 Jan. 17, 1922 Washington D.C. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or homa 23a or 28a-f show other traumatic avant, the Medical Examiner must be notified at Yes 2 No Director Prince George Hyattsville 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 6020 Sargent Road Apt 2105 20782 U.S.A. Funeral death 12, Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black White etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: λq Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Cottege (1-4or 5+) 12 File Clerk Fed. Government is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Isam 27 Is marked other any injury or other traumatic avant 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin F. Parker Emma Moore 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) 94577 Vinetta Johnson Daughter 150 Haas Avenue Apt. 201 San Leandro, California 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland Baltimore Washington Crem. Signature of Funeral 89 22. Name and Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finat PANCREATIC MOS disease or condition resulting in death) Examiner Examiner physician and the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760 Physician/Medical Due to (or as a consequenca of): 88 980 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Wes an eutopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? Completed D990 788 1 Yes 2 DNo 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Hospital: 10 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t i or Attanding F 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homleide To the Hospital or within 24 hours aff To the Funeral Di complataly filled in edical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 MS 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEPHENU STAR 1221 UPERCHUTILE LA ULO 20774 CARGO 31. Date filed (Month, Day, Year) 32. Degistrar's Signature MAY 1 9 2000 Registrar



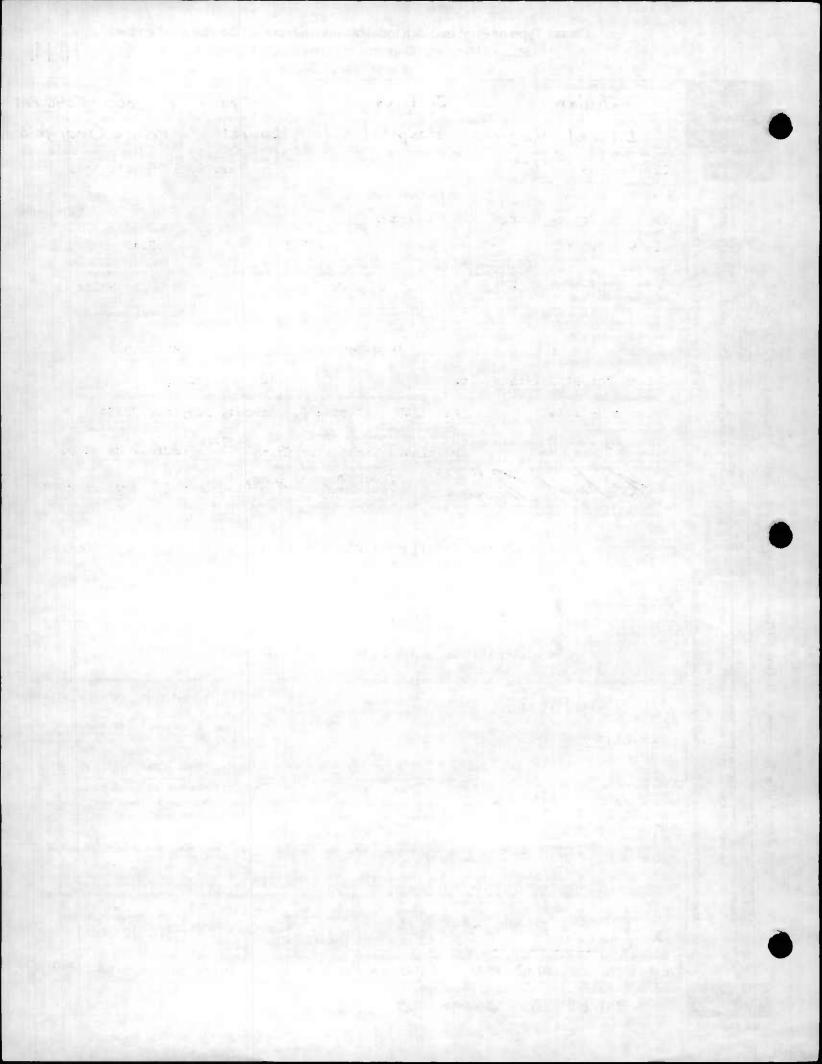
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State of Maryland / Department of Health and Mental Hygiene

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			Ce	rtificate of	Death		Reg. No.		17011
Dhuaisian	1. Decedent's Name (First, Middle, L.	ast)	- CC 1			2. Date of De	eath Day	Yeer	3. Time of Death
Physiciar /Medica	Julian		Jeffrie			May	9, 2	000	5:40 PM
Examine	An Facility blaces /th and institution at	Regional	Hospi	tal	L	aurel	Prin	ce (George's
Funeral Director		Sex 7. Age (If	yrs. last birthdey, Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bi (Month, Do Mar. 2	oy, Year) 0 1936	9. Birthp Cour Virg	place (Stete or Foreign htry) inia
Mend Mend	10a. State 10b. County	10	c. City, Town or L	ocation				1	0d. Inside City Limits
free death with the Manyler frem 23a or 28a-f show the must be notified at	MD Prince 10e. Street and Number	George	Laur	e1			10g. Citizen of	What Cour	YYes 2 No
23a or				2	20707		U.S.A	١.	
Urs a	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eval Armed Forces? 1 X Yes 2 No If Yes, Give Year or Datas:	r In U,S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)		ck, White,	can Indian, etc. ite
Z1Z15-00ZU d within 72 hours af giene. r than "naturel", or in Medical Expert	15. Decedent's E (Specify only highest gi	ducation ade completed)	(Give	dent's Usuel Occup	durina most o	f working	16b. Kind of B	usiness/in	dustry
within within then.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)			1 . 1	
		<u>Ø</u>	Au	to Mechar		Name (First, Middle	Automo		
_ ~ ~ ~ ~ 0	Julian Forest J	effries, Sr.			I	da Star	ling		
2 shou send M is man	19a. Informant's Name/Relationship	(Type, Pnint)	19b. Mail			or Rurel Route Numb			Code)
F W 64 F	Roberta Jeffrie			Ellertor	s. I	aurel, Ma	-		
0 8 2 5 7	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Control o	Removal from State		osition (Neme of emetory or other ple Washingt		5-11-00	Laurel,		
Darrill Pag Depertment Important: I any Injury o	21. Signature of Funeral Service Lice	MOC MICH	587 F	2. Nama and Address Fune	eral Ho Sprin	me, Inc. ng Road La	urel, Ma	ryla	nd 20707
Physician	23a. Part1. Enter the diseese, or cor shock, or heart failure. List only	nplications that caused the vone ceuse on each line.							Approximata Interval Between Onset and Deeth
/Medical Examiner	Immediate Ceuse (Final disaasa or condition resulting in death)	a CARDIO			ARRES	T			Hour
	ĕ	b. CARDIO	to (or as a conse						Houn
A CO COU, entificate be assecuted and physicien and se es the buntal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CARDIAC	to (or as a conse	quence of):	Α .				House.
Certific Cer		d. CHRONIC	01357	TRUCTIVE	Puu	MONARY	DISEASE		
thet the death ed by the atter	Part II. Other significant conditions If YPERTENCY	contributing to death but no	ot resulting in tha	undarlying cause gi	ven in Part I.	23b. Dld	tobacco usa co	ntribute t	o the cause of death
		DIV				1	Yes 2□ No	3 Pro	bably 4 Unknow
N 8 5 8 1	OBESITY.						s an autopsy ormed?	av cc	fere eutopsy findings vailable prior to ompletion of causa death?
The law ate has b page 2 s	Ē					10	Yes 2 No		☐Yes 2☐No
cartificate rector, pag					26. Place o	of Death (Check only	- /		7163 2010
Physician: this cartific ral director,	axeminar? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatie	ent 3 DOA Ot	hor:	ing Home 5 Res		ner (Speci	(y)
oding Phys th. : After this a funaral d		28a. Dete of Injury (Month, Dey Ye	28b. Time	of 28c. Inju	ryet rk? ∣Yes 2 □ No		how injury occur	rred	
DIVISION Call or Attending P setar death. al Director: Attent ed in by the funers	3 Suicide 6 Could not determined	28e. Place of Injury building, etc. (5	At home, farm, s	treet, factory, office			(Street end Num wn, Stete)	ber or Run	al Route Number,
To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	29a. Certifier 12 Certifying P	hysician: To the best of m miner: On the basis of exe and manner stated	amination and/or in						
To the within To the comple	29b. Signature and title of certifier	br MD.		29c. Licans	sa number		29d. Date signe		
6	PADMAJA S. U.	completed causa of death		, Print) VAN DUS	EM RO	AD SWITE	380 L	AURE	L 20707
State Registrai	2224 4 0 00	32. Registrar's	- 4	Loan					

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State of Maryland / Department of Health and Mental Hygiene

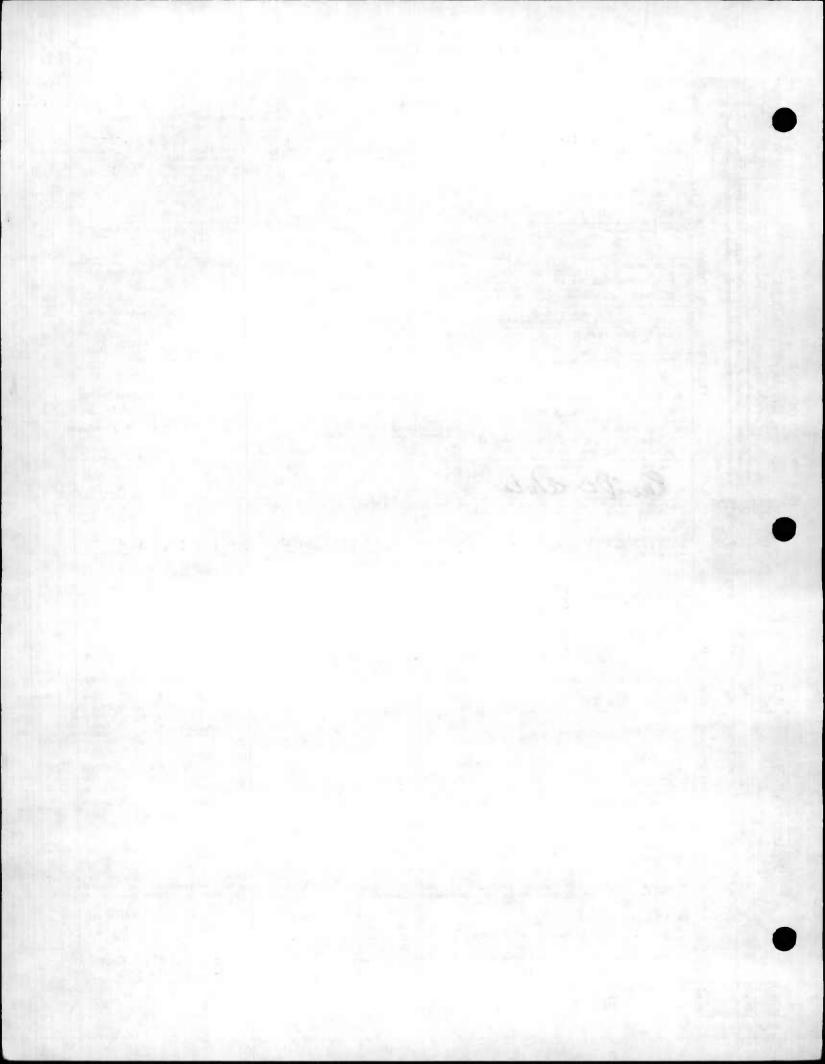
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				Cei	rtificate	e of	Death		-1	Reg. No.		17010
Dhysisian	1. Decedent's Name (First, Middle,	Last)	100						2. Date of Dec	Day	Year	3. Tima of Death
Physician /Medical	VIOIA May Jewe								May 13,			6:30 P.M
Examiner	de Casilita Nama (Mast Institution						CUMB	ERL	AND		ty of Death LEGAN	1Y
Funeral Director	232-26-1598	3. Sex 1 □ M 2 ∏ F	7. Age (In yrs. I 86	ast birthday) Yrs.	If Undar Months	1 Yaar Days	If Under Hours	24 Hrs. Min.	8. Date of Birt Month, Da JAN . 22	2,1914	9. Birthp Court WEST	laca (Steta or Foreign VIRGINIA
3	Usual Rasidence of Decedent 10a. State 10b. County		10c. City	. Town or Lo	ocation	_		_			1	0d. Inside City Limits
be notified at		NY		MBERLA	AND	0.1				10- 02		1 Yas 2 No
		STREET				502				10g. Citizen of	.A.	
Examiner must by Funeral	3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 No		Was Deced If Yas, spec 1 ☐ Yes 2			gin? (Sp , Puerto	pecify Yas or No Rican, etc.)	Speci	ica - Americack, Whita,	atc.
t, the Medical	15. Decedent's (Specify only highast Elementary/Secondary (0-12)	Education greda complated) Collega (1	-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	rk dona se retire	eation during most d)	t of work	ing	16b. Kind of I	Businass/Ind	dustry
		ast)		HOL	TEMAKE		18. Mothe	er's Nam	e (First, Middle,		me)	
To Be		DRICK					MAY	ELI	ZABETH	MATTHE	V	
	19a. Informant's Name/Relationshi			19b. Maili	ng Address	(Street	end Numbe	er or Rui	ral Routa Numbe	er, City or Town	n, Stete, Zip	Code)
	KATHLEEN M. ALE	BURTIS/DA		16814	-		ROAD,	NW	- ECKHA	RT, MD	2153	
	20e. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Spe		Steta	r ASHE	matory or o	ther ple				FORT A		
Bucs	21. Signature of Funeral Service Li	Sensee How him	ich)						HOME, P.		21502)
	23a. Part1. Entar the disaasa, or cashock, or heart tailure. List or	omplications that conly one causa on a	aused the death ach lina.								21302	Approximate Interval Between
	Immediate Cause (Final	0.		1								Onset and Death
al er	Immediate Cause (Final disease or condition resulting in death)	a. C17				ccT	TVIZ 1	lun	VC DI	CHARE		LNKNSun
ledical Examiner			Due to (or	r as a consec	quance of):							
Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying	b	Due to (or	r as a consec	quenca of):					7.74		TI SE
/Medical	that initiated events resulting in deeth) Last	C	Due to (or	as a conseq	quance of):							
		contributing to de	eath but not resu	ulting in the u	inderlying c	ausa ni	ven in Pert I		23b Dld	lobacco use c	ontribute to	o the cause of death
Physician	CONCRE			7						Yes 2 No		bebly 4 ☐ Unknow
Completed by Physic			Mother	A						an autopsy	SV	ere autopsy findings allable prior to empletion of causa death?
Con	DEME	NTIA							10	Yes 2 PNo	1[☐Yes 2☐No
B B	25. Was case referred to medical examiner?					100		of Dea	th (Check only o	one)		
funeral director,		28a. Date (Mont	inpatient 2 of Injury th, Dey Year)	28b. Time o Injury		8c. Inju Wo			28d. Describe			(y)
Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicida detarmin	t be 28a. Place	of Injury - At ho ng, atc. (Specify	ome, farm, sti			165 20	110	28f. Location (: City or Tox		nber or Rure	al Route Number,
completely filled in by the funeral Medical Certification:		Physician: To the caminer: On the ba	asis of examinat									
completely filled in by the Medical Certifical	29b. Signatura and title of certifiar						se number			29d. Date sign	ned (Month,	Dey, Year)
3) seco	un			1	02	6907		7/1/	May (4	2000
2	30. Name and address of person w		a of death (Item	23a) (Type,	Print	11	? /	1			1)	
MS	Haryit Schul	4.0.925	Dishop	walsh	Koa	d	umbe	rla	nd M	11) 215	02	
State Registrar	MAY 1 8 2000	32. R	egistrar's Signa	tura de	south	/						

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		State of Marylai		e of Death	R	eg. No.	1/3/6
Physician	Decedent's Nama (First, Middle,	3"			2. Dele of Deal Month	Day	3. Tima of Death
/Medical	JOSEPH ROO 4a Facility Name (If not institution,	SEVELT JOHN give street and number)	SON	4b. City, Town, or	May	11 20 4c. County of	
	Civista Medical	Center		LaPlata		Ch	arles
Funeral	5. Social Security Number 6	Sex 7. Age (In yrs.	last birthday) If Under Months		8. Dete of Birth (Month, Day		Birthplace (State or Foreign Country)
Director	216-12-4786	1MM 2□F	79 Yrs.	So	eptembe	r 14.19	920 Maryland
P .	Usual Residence of Decedent	I.o. o	- T				
ahow	10a. State 10b. County		ity, Town or Location	-211-			10d. Inside City Limits
the Maryle 28s-f aho notified at	MD St. M	ary s	Mechanicsy	/111e			1 ☐ Yes 2 No
th with the Ma 23a or 28a-fa at be notified al Director	10e. Street and Number 28535 Flora	Corner Road	10f. Zip	20659	1	0g. Citizen of Wi USA	nat Country?
5-0020 72 hours effer death with the Maryland naturel; or items 23a or 28a-f show dieal Examinar must be notified at sted by Funeral Director	11. Marital Status No Never Married 2 Marrie 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 No If Yas, Giva Year or Dates:	J.S. 13. Wes Deced If Yes, spec	eni of Hispanic Origin? (S ify Cuban, Mexican, Puerl No Specify:	pecify Yes or No- o Rican, etc.)		- American Indian, , White, etc. Black
L c	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a. Decedent's Usua (Give kind of wor life. DO NOT us	l Occupation is done during most of wor e retired)	rking	16b. Kind of Bus	iness/Industry
Marie S	4		Farmer			Farm	
Du strain	17. Father's Nama (First, Middle, La	st)		in a separate and a s	me (First, Middle, I		
VID Went Went Research	James Alfred	Johnson			Elizab		
Maryland 2: and 2 should be filed v and 2 should be filed v and 2 should be filed v 27 is marked other t or treumatic event, in To Be Co	19a. Informant's Name/Relationship Arline Short/						csville,MD
Baltimore, Maryland 212 pamit. Pages 1 end 2 should be filled with Department of Health and Meniel Hyglene. Important: if Item 27 is marked other than ny injury or other traumatic event, the Menia. To Be Comp	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		Place of Disposition (Namcemetary, cremetory or of	ne of ther place) orial Gar.			city or Town, Stele
Baltir Permit. P Department Importan eny injur	21. Signature of Funerel Service Lie	ensee / M0094	5 22. Name en	d Address of Fecility	ole Fun	owal U	omo D A
_ 020	Klevel C.	Shill	DI IIIS	sfield-Ech	borlott	o Unll	MD 20622
Physician /Medical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Finel disease or condition resulting in death)	. HEPA-		_ULAR			
Box 68760, seth certificate be associated attending physicien end for use as the buriet-transit	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	or as a consequence of):				
death death ed for u	Part II. Other significant conditions	contribution to doubt but not m	culting in the underbring of	ture gives in Red I	23h Did to	hacco use cont	ribute to the cause of death?
ds, P.O. Box ires that the death cent signed by the attending d be detached for use d by Physician/M	Parti. Other arginican conduction	Continuously to obatin but not re-	soming in the uncertying ca	suse given in Fait i.	1 U Y	10	3 Probably 4 Unknown
aw requires been 2 about					24e. Wes e perion	n eutopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Recreician: The law sident: The law director, page 2 a director,					1 🗆 Y	es 2 No	1 ☐ Yes 2 ☐ No
Vital sicien: Tr certificate lirector, pe	25. Was case referred to medical			26. Place of De	ath (Check only or		
of Vita Physician: this certification of interestination of the control of the co	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 DO	Othor	fome 5 ☐ Reside		(Specify)
Vision of Attending Physic death. ector: After this by the funeral did the funeral discallen: To	27. Manner of Death 1) Natural 5 Pending 2 Accident investigat	28a. Data of Injury (Month, Day Year)		8c. Injury at Work?		ow injury occurre	
Division of tall or Attending P ra after deeth. el Director: After t led in by the funera	3 Suicide 6 Could no 4 Homicide determine		nome, ferm, street, fectory	, office	28f. Location (S. City or Town		r or Rurel Route Number,
DIVISION Of VITAI Re To the Hospital or Attending Physician: The is within 24 hours after deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com		Physician: To the best of my kn aminer: On the basis of axamin and manner stated.					
Within To the complete	29b. Signatura and title of certifier	00	290	. License number	2		(Month, Day, Year)
	N. Anm	augard		D - 26064			12-2000
	30. Name and address of person w Vidyasagar Anma		11/1	. 5 & Golder arlotte Hall	n Beach R l, Maryla	d., P.O and 2062:	.Box 282
State Registrar	31. Date filed (Month, Day, Year)	2000 32. Registrar's Sign	atura B. A.	books			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Hilda M. Jenkins 12:30 AM MAY 2000 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Salisbury Waterview Healthoare Wicomico 7. Age (In yrs. last birthday) Yrs. If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) Months Days Hours 218-24-4357 Usual Residence of Decedent 1 M 2 KF Maryland 10c. City, Town or Location 10d. Inside City Limits 14 Yes 2 No WORCESter SNOW 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2186 57 1 ted State 14. Raca - American Indian, Black, White, etc. United . Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No Specity. Specify: BIACK 3 Widowed 4 □ Divorced 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Abover oultr 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Mart reorge Daniels 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bay ST 3/2 SNOW Hill, Md 218 Date 20c. Location - City or Town, State md 21863 News Waters Deloves 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stete WES ley 13/005NOW 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M. Source 22/7/ wharton Rd plications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. HCCOMAC 23e. Pert1. Enter the disease, or com-shock, or heart feilure. List only Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AMEROGELETIC CARDIOUAS CUITAV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): thet Initiated events resulting in death) Last Due to (or as e consequenca of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown CVA 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes ✓ No 25. Was case referred to medical 26. Piece of Death (Check only one) Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation + Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homlcide

Box 68760. P.0. Records, of Vital Division

The law requires that the deeth certificate be executed ettending physician and for use es the bunal-tran this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Pages 1 end 2 should be filed within 72 hours after inent of Heelth and Mental Hygiene. Int: If Item 27 Is marked other than "naturel", or ite

permit. Pages 1 and 2 s Department of Heelth ar Important: if Item 27 is eny Injury or other treu once.

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Certification:

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29a, Certifier

(Check only one)

treumstic event, the Medical

Baltimore, Maryland 21215-0020

death v

Director

Funeral

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Completed

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State Registrar wound &

29c. License number D 32014

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

106 WILFORD- 9+ 50UB SULISBURY MAHESH MODUDEA 32. Registrar's Signeture

31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

Maunh

hanfriam "-81-45 218-24-4551 X My mercenes symmethy M 312 5 13 4 United States George Mastin Delotes when Never 312 S way ST Swam - 11 ml 21253 THE WESTER COM. STYCESHOW HILL MA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** Sadie T. Kaplan May 14, 2000 8:15 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brighton Gardens Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 89 Yrs. Director 579-34-3350 April 15, 1911 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1∑ Yes 2 No Director MD Montgomery Rockville r 28s-f 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Norms 23s. 5550 Tuckerman Lane 20852 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. ital Hygiene. ed other than "natural", or item event, the Medical Examiner. pemit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any Injury or other traumetic event, the Medical Examines. 1 ☐ Never Merried 2 ☐ Merried Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White P 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Owner/Operator Fabric Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be David Taetle Mary E. Smulian 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 19a. Informant's Neme/Reletionship (Type, Print) 10500 Rockville Pike, Apt #1607, Rockville, MD Ruth C. Boorstein/ Daughter Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete May 16, 4 □ Donetlon 5 □ Other (Specify) Shaarei Tfiloh Cemetery Baltimore, MD 2000 22. Name end Address of Fecility 21. Signeture of Funerel Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 Approximate Intervel Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert feilure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical AORTIC STENOSIS Examiner Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): the burial-trar attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical that initiated events resulting in deeth) Lest Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 □ Yaa 2 □ No 3 Probably 4 Unknown ARTHEROSCLEROTIC CEREBROVASCULAR DISEASE bengis be del 2 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? peed completion of cause of death? has 1 ☐ Yes 2 1 No 1 Yes 2 No certificate Attending Physician: funeral director, Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this 28e. Date of Injury (Month, Dey Year) 27, Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of After 1 Natural 5 Pending s effer de... al Director: Affe 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital ... within 24 hours effer deets To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one) 29b. Signature and tale of ourtiller 29c. License number 29d. Date signed (Month, Day, Year) May 16, 2000

State Registra

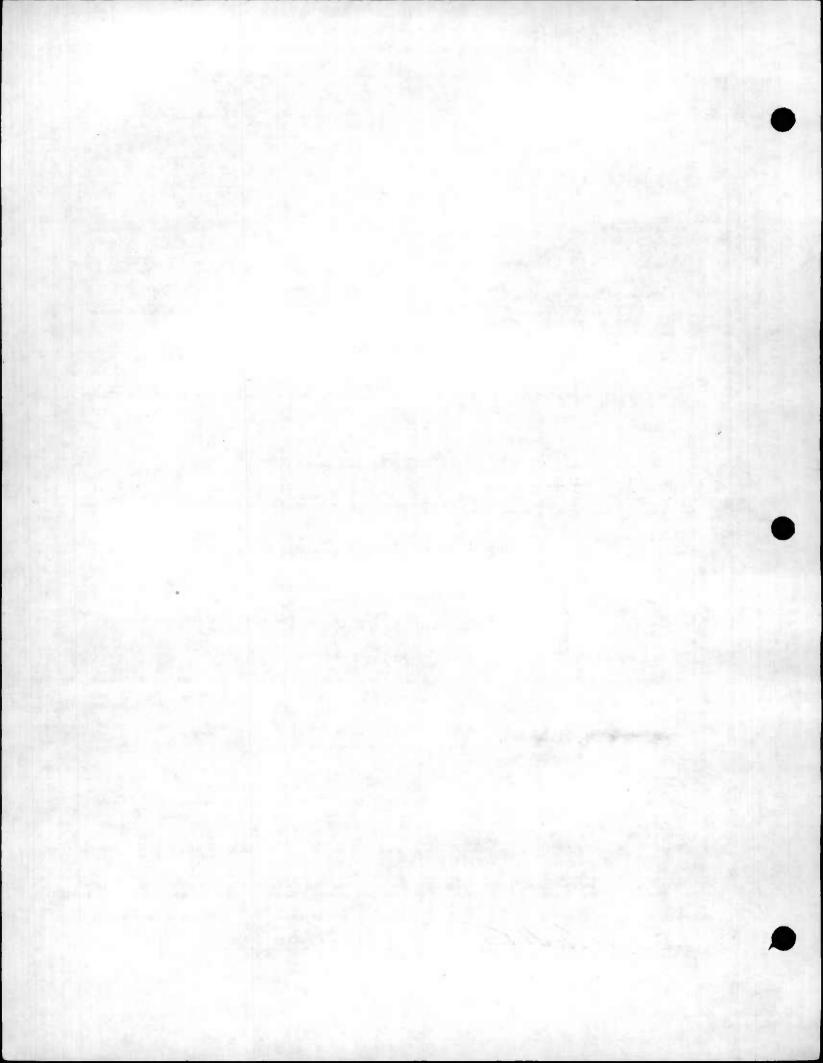
31. Dete filed (Month, Day, Year) MAY 18 2000

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

STANLEY M. SILVERBERG - 5454 WISCONSIN AVENUE #925 - CHEVY CHASE, MARYLAND 20815 32. Begisfrer's Signeture Freedo

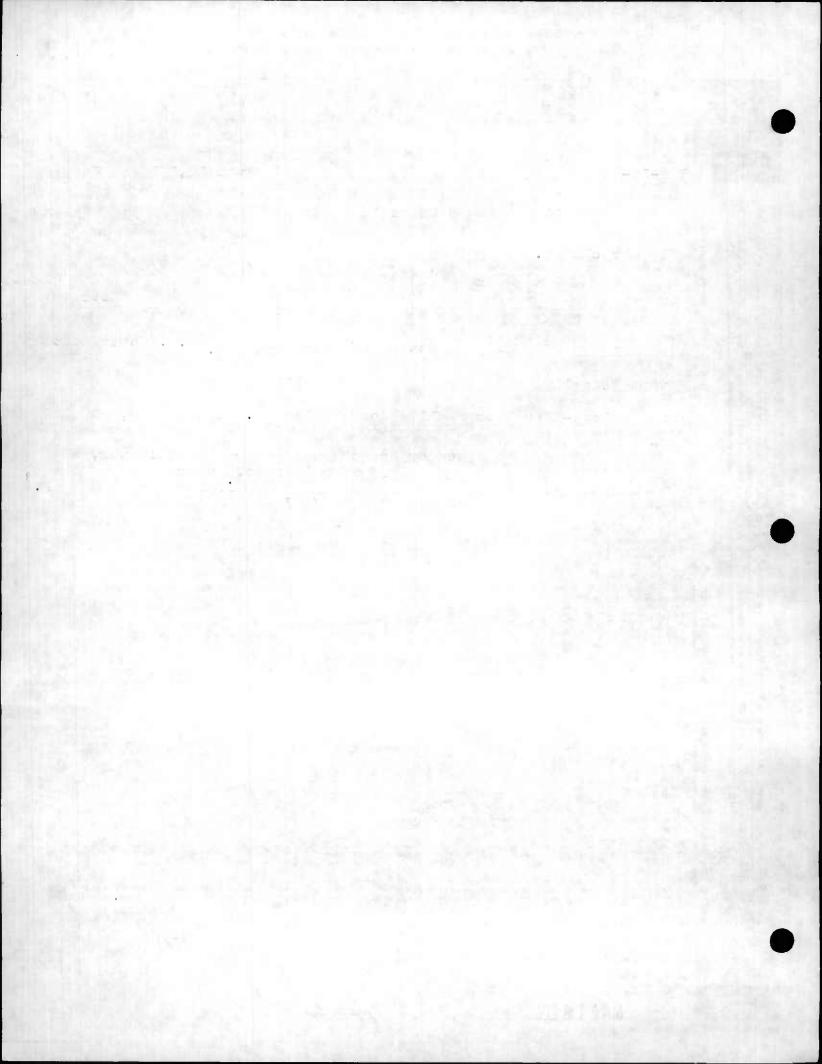
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 7

	Certificate of De	eath Reg. No.
Physician /Medical	1. Decedent'a Name (First, Middle, Last) Edward C. Kennelly	2. Date of Death Month Day 13 th 2000 12 10
Examiner	Copper Ridge	City, Town, or Location of Deeth 4c. County of Death Sy Kesulle Carroll
Funeral Director		Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or For Country) June 13,1916 New Jersey
Man	10a. State 10b. County 10c. City, Town or Location	10d. inside City L
to the part	MD Carroll Sykesville	1 ☐ Yes 25
ter death with the Marylan items 23e or 28e-f show iner must be notified at funeral Director	10e. Street and Number 10f. Zip Code 710 Obrecht Rd. 21784	10g. Citizen of What Country? USA
ar, or the Examine by Fur	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, M If Yes, Specify Cub	nic Origin? (Specify Yes or No- Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
ed within 72 ho ygjene. wr than "natur r, the Medical. Completed	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done durit life. DO NOT use retired)	n 16b. Kind of Business/Industry
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	12 5+ Attorney/Gove	rnment Ser. (First, Middle, Maiden Sumame)
o sed of		
d Men marks marks		Ella Farley Number or Rural Route Number, City or Town, State, Zip Code)
7 10 10 10 10 10 10 10 10 10 10 10 10 10		ley Rd. Westminster, MD 2115
Heal Star	20a Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
0 m 0	→ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)	F 00 T
ortant injury		metery 5-20 Westminster, MD
O T P O	412 Washi	"Facing ritts Funeral Home & Char ngton Rd." er, MD 21157
Medical saminer used and saminer Examiner Examiner Examiner	Immediate Cause (Final disease or condition resulting in death) a.	mentra year
ng physicia es the bur Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
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ed by detac		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Uni
cate has been signed by the attending physicial page 2 should be detached for use as the bur Completed by Physician/Medical		24e. Was an eutopsy performed? 24b. Were autopsy find aveilable prior to completion of caus of death?
fo Be Comp		1 ☐ Yes 2月 No 1 ☐ Yes 2月 No
certificate rector, pag	Avaminar?	6. Place of Death (Check only one)
this certific ral director.		4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
or death. octor: After th by the funeral	2 Accident	28d. Describe how injury occurred s 2 □ No
can or Attending resident death. al Director: After to led in by the funeral Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number City or Town, State)
n 24 hound to Funer pletely fill edical	29a. Certifier (Check only one) 1© Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion and menner steted.	date end place, and due to the cause(s) end menner es stated, on, death occurred at the time, dete end place, and due to the cause(s)
within Toth	29b. Signature and title of certifier Emerine Wright, MD 29c. License no. D 5.	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ernestine Wright, Copper Ridge, 7(0 Obrec	2740 May 5/15/00 tht Road, Sykes ville MD 217
State Registrar	31. Date filed (Month, Day, Year) MAY 1 6 2000 Separate Signature	



Ple	ase Type or I	Print in E	Black Ir	ndelible	e Ink	Assur	re A	II Coples	Are Leg	lble.	
		of Maryland	nd / Depa		nt of H	Health ar		Mental Hy	_	0	17320
1. Decedent's Name (First, Middle	le, Last)						1	2. Dete of De	eeth	Vaar	3. Time of Deeth
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4e Facility Neme (If not institution		mber)			- 1	4b. City, Towr	m, or Lr	ocation of Deeth	-	y of Deeth	
Holy Cross Hos	prital				- 17	Silver	Sp	rino	Mor	tgome	277
5. Social Security Number	6. Sex	7. Age (In yrs. I	lest birthdey) If Under Months	r 1 Yeer	If Under 24	24 Hrs. Min.	8. Dete of Bird (Month, De	rth Voor)	9. Birth	plece (State or Foreign intry)
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Usuel Residence of Decedent		12- 04	- cont		-11						
10a. Stete 10b. County	Acres To Section	10c. Uny	ty, Town or Lo	ocation							10d. Inside City Limits
Maryland Montg	omery	S	Silver	Sprin	ng						1 ☐ Yes 2 ☑ No
10e. Street and Number				10f. Zip			III		10g. Citizen of	What Cour	ntry?
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17. Father's Neme (First, Middle,	, Last)					18. Mother	's Nsm		s, Maiden Sumen		/CIII j
Wilson Kell						Mar	the	IInl	cnown		
WILSON Kell 19e. Informent's Neme/Reletions			19b. Meil	lina Addres	e (Street				CNOWN ber, City or Town	State, Zi	in Code)
		`									
John W. Kelly	(s	on)	802 F			reet	Sil	Ver Spr	ring, Mar		
20a. Method of Disposition	3 Removel from	Cé	cemetery, cre	metory or o	other plsc	ce)	1	DSTO	20C. LUCATION	- City or 1	own, Sista
4 Donetion 5 Other (S			chill	Cemet	tery	455	5	/20/00	Burnham	Penr	nsylvania
21. Signature of Funerel Service	Licensee		2:	22. Neme en	nd Addres	ess of Fecility	/				
· Which	Chupal	,							l Home,		1m 20001
23a. Pert1. Enter the diseese, or	complications that c	raused the dest!								ring,	, MD 20901 Approximete
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resulting in death) Last				, and a second							
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The state of the set and is	to the steep to at		and the sheet	1 data		1 Deal		ogs Did		- dhada	and death?
Part II. Other significant condition	Ins continuing to de	Ath but not resu	alting in the u	Indenying 6	ause givi	en in Pert I.					to the cause of death?
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1 ☑ Neturel 5 ☐ Pendin investig	igetion	of Injury oth, Dey Year)	28b. Time o tnjury	of 2	28c. Injun Work	inyet ork?]Yes 2 ☐ No		280. Describe	how Injury occur	red	
3 ☐ Suicide 6 ☐ Could r	not be 28e. Placa	a of Injury - At ho	ome ferm s'	treet, fector	v. office			28f. Location	(Street and Num	ber or Rui	rel Route Number,

Examiner Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

27.

29a. Certifier

Physician /Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 22e or 28e-f show

Baltimore, Maryland 21215-0020

other traumatic event, the Medical Examiner must be notified at

any injury or

Physician /Medical To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burlet-transit completely filled in by the funeral director, page 2 should be deteched for use as the burlet-transit

29b. Signeture and title of cartifier

tto Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

2 ■ Medicat Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated.

29c. License number D 0005568

29d. Date signed (Month, Dey, Year)

May 16,2000

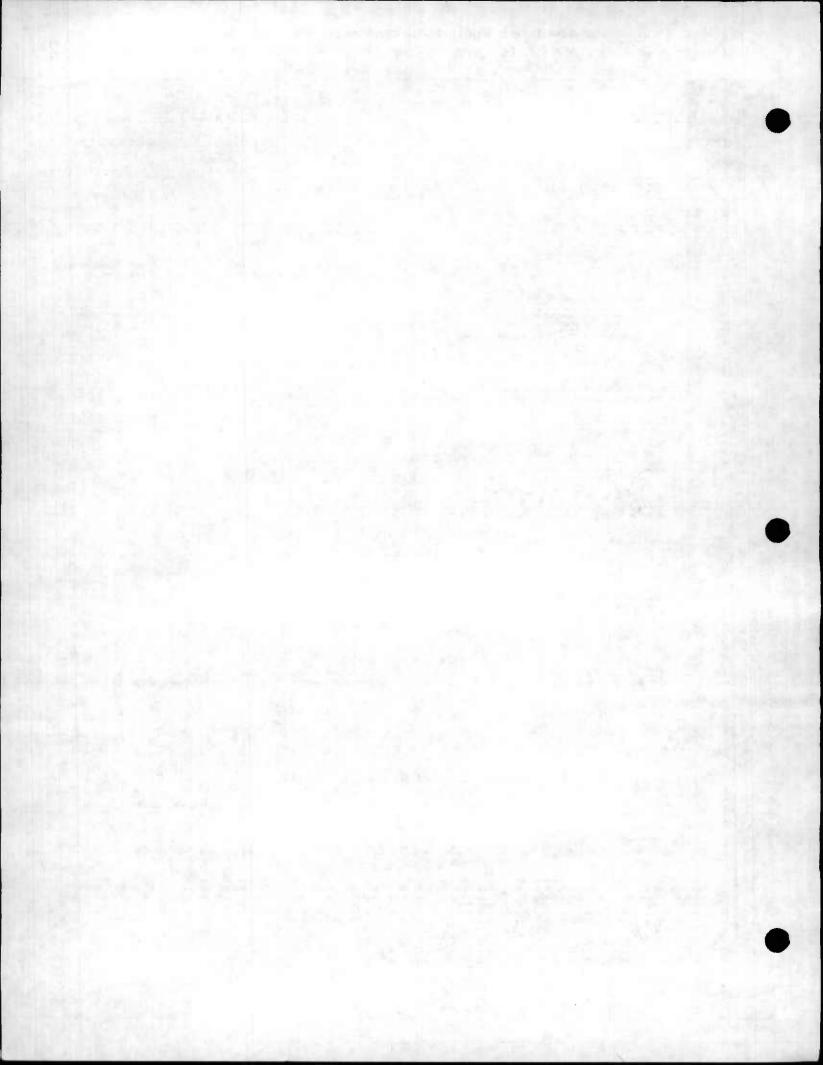
30. Neme and eddress of person who completed cause of death (Item 33a) (Type, Print)

Samuel Itscoit
31. Dete filed (Month, Dey, Year) 10313 Georgia Avenue #306 Itscoitz M.D Silver Spring, Maryland 20902

State Registrar

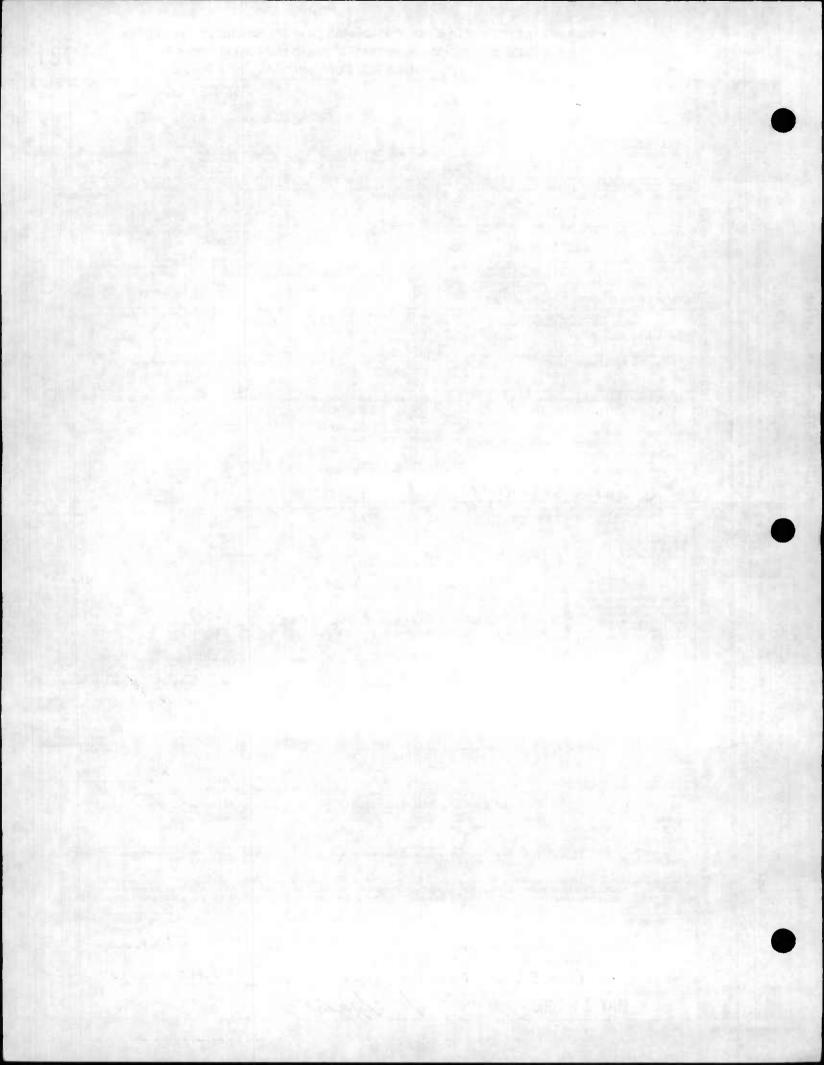
MAY 1 9 2000

32. Registrer's Signeture



acility Name (First, Middle, La JOHN KELLY acility Name (If not institution, given the property of the proper	KILBOURNE, re street and number) RE MEDICAL CE Sex 7. Age (tn 62 LL DRIVE 12. Was Decedent Ever Armed Forces? 1 1 4 9 2 2 No if Yes, Give Year or Dates: ducation ade completed) College (1-4or 5+) 6 R KILBOURNE Type, Print) OURNE (WIFE)	NTER yrs. last birthday) Yrs. City, Town or Location 10. 13. Was if Ye in Y	on SYKESVI 10f. Zip Code 2 3 Decedent of Hi ss, specify Cubar Yes 2 No	21784 ispanic Origin? (Sp n, Mexican, Puerlo Specify:	8. Date of Birl (Month Da April) April	Day 14 2 4c. County BALT 15, 1938 10g. Citizen of V	Year 000 07: of Death IMORE 9. Birthplaca (Security) 3 MARYLA 10d. Institute 11 What Country? USA a - American Indick, White, etc.	side City Limits ☑ Yes 2월 No
REATER BALTIMOR clai Security Number 6. S 6-34-4777 Residence of Decedent State 10b. County CARRO Street and Number 1321 HILLCREST aritaf Status Never Married 2 Married Widowed 4 Divorced (Specify only highest grammentary/Secondary (0-12) athar's Name (First, Middle, Last, MAURICE COMPHE Informant's Name/Relationship (5. MARY L. KILBO Wethod of Disposition Burial 2 Cremation 3 C Donation 5 Other (Specify	PRIVE 12. Was Decedent Ever Armed Forces? 1 Yes 22 No If Yes, Give Armed Forces? 1 Yes 22 No If Yes, Give Armed Forces? 1 Yes 22 No If Yes, Give Armed Forces? 1 Yes 22 No If Yes, Give Armed Forces? 2 2 3 3 3 3 3 3 3 3	NTER yrs. last birthday) Yrs. City, Town or Location 10. 13. Was if Ye in Y	on SYKESVI 10f. Zip Code 2 3 Decedent of Hi ss, specify Cubar Yes 2 No 's Usual Occupa d of work done d NOT use retired,	TOWSON If Under 24 Hrs. Hours Min. LLE 21784 ispanic Origin? (Sp., Mexican, Puerto Specify:	8. Date of Bir (Month, Da April	BALT The Year) 15, 1938 10g. Citizen of V	of Death IMORE 9. Birthplaca (Scountry) MARYLA 10d. Institute What Country? USA a - American Indok, White, etc.	Stata or Foraign ND side City Limits ⊇Yes 2X No
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anner of Death Natural 5 Pending	28a. Dete of Injury (Month, Day Yea				28d. Describe	how Injury occur	red	
Accident Investigation				Yes 2 No	001 1	O	0 - 10	- A6
☐ Homicide determined	266. Placa of injury - /		factory, office		City or To	wn, State)	er or Hurai Hou	e rvumber,
	vercian: To the best of my	knowledge, daath oc	curred at the tim	ne, data and place.	and due to the	cause(s) end me	enner as stated.	
Certifier 174 Certifying Ph								ause(s)
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(Check only 2 Medical Examone) 2 Medical Examone) Signeture and title of certifier Duilliam	Benedict, Mis	(item 23a) (Type, Prin	nt)		0	111		
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KILBOURNE, JOHN Kelly



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Margaret T. Kelly May, 16, 6:45 AM 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery If Under 24 Hrs Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Dey, Year) Sept. 2, 1910 5. Social Security Number 7. Age (In vrs. last birthdev) **Funeral** Months Days Hours 10 M 20 F 579-44-9686 89 Wash., DC Director Usual Residence of Decedant 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County e tiled within 72 hours after death with the Maryls al Hygieth other than "natural", or flams 23e or 28e4 ahov vent, Its Medical Examiner must be notified at none Washington, D.C. none 1 Yes 2 No Director 10f Zip Coda 10e Street and Number 10g. Citizen of What Country? 2718 Arizona Ave., N.W. 20016 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yas, Give Year or Datas: 1₺ Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: white 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry Archdiocese of Elementary/Secondary (0-12) 12 College (1-4or 5+) San Francisco secretary pemil. Pages 1 and 2 should be fin Department of Health and Mental Hy Important if Nem 27 is marked oths atty Injury or other trauments 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be 2 Eugene Kelly Mary Frances Mills 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Robert J. Kelly/brother 2718 Arizona Ave., N.W., Washington, DC 20007 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town. Stete 20a. Method of Disposition Data 1 Burial 2 Cremetion 3 Removal from Stete Mt. Olivet Cemetery May 19,00 Washington, D.C. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility DeVol Funeral Home 2222 Wisconsin Ave Wisconsin Ave., Washington, D.C. 20007 Approximate Interval Between Onset and Death ntar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on aach lina. **Physician** /Medical Immedieta Causa (Final encephalitis weeks disease or condition rasulting in death) Examiner Due to (or as a consequence of). Examine herpes weeks sician end bunal-transit Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Causa (Disease or Injury that initieted events resulting in death) Last Dua to (or as a consequence of): Box 68760. physician certificate be Physician/Medical the Due to (or es a consequence of) 98 980 P.O. Part ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? the deteched 3 1 Yee 2 No 3 Probably 4 Unknown signed t Records. by leted 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Compi has 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerei 27. Menner of Death 1 Natural 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Division Attending 5 Pending invastigation i Director: Af death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by after 4 Homicida Hospital of 24 hours a To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and dua to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Dey, Year) 29b. Signeture end fitte of certifier

DHMH 16 Rev 6/95

6

State

Registrar

4910 Mass. Ave.

32. Registrar's Signeture

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

2000

Michael Grady, M.D.

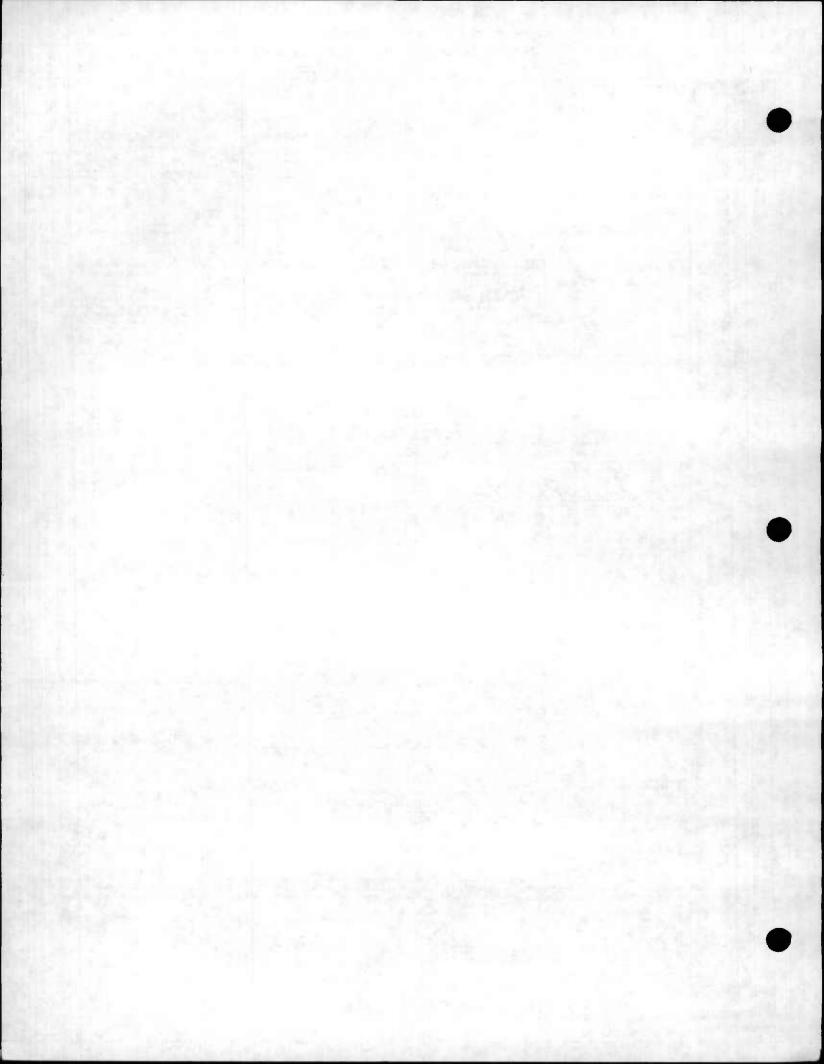
17

31. Dete filed (Month, Day, Year)

D38781

#210, N.W. Washington, D.C. 20016

May 16,2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death Month 3. Time of Death **Physician** FRANK (NMN) KRAGL, 2000 May 16, 8:25 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** NOM 2DF Yrs. 218-18-7901 Director 79 Sept. 29, 1920 Yugoslavia **Uauat Residence of Decedent** 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 Yes 2 No Maryland Harford Churchville 10e. Street and Number 10g. Citizen of What Country? 2916 Coale Lane 21028 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 28 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, apecify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11 Marital Status 1 Never Married 2 Married 6 1 Yes 25No Specify: À 3 ☐ Widowed 4 ☐ Divorced n res, Give Year or Datas: White Completed 16a. Decedent'a Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT use retired) filled within Elementary/Secondary (0-12) College (1-4or 5+) 11 Cabinet Maker Woodworking 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental James Vaclav Kragl Cecilia U/K 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Bonnie Kragl Day - Daughter 3801 Longley Road, Abingdon, Maryland 21009 altimore. 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Burial, 2 Cremation 3 Removal from Stata Calvary U.M. Cemetery 5/19/00 4 Donation 5 Other (Specify) Churchville, Maryland 21. Signature of Funeral Sen 22. Nama and Addrass of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 in the weath. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximata Interval Between Onset and Death 23a. Part | Enter the dista **Physician** Immedieta Causa (Final disease or condition rasulting in death) /Medical Examiner Physician/Medical Examine JM410 Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown The law requires that 24b. Wara autopsy findings available prior to Be Completed 24a. Was an autopsy performed? Chrononeulm Disense completion of cause of death? this certificate has 1 Yes 2 No 1 Yes 2 No Vital 25. Wes casa ratemed to medicef 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 9 No Certification: To 1. Inpatient 2 ER/Outpatient 3 DOA 50 28a. Date of Injury (Month, Day Year) 27. Mapher of Death 28c. fnjury at Work? 28d. Describe how injury occurred 28b. Tima of Atter Division 1. Netural 5 Pending i or Attanding after death. 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, atreet, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 1 Normal Physician: To the best of my knowledge, death occurred at the time, date and place, end dua to the cause(s) and mannar as stated.

2 Normal Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and titla of certified 29d. Data signed (Month, Day, Year) person who completed ceuse of death (Item 23a) (Type, Print) MNIOH Aegistrar's Signatura State

DHMH 16 Rev 6/95

Registrar

MANY I COME PORT OF HAME

Robert

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

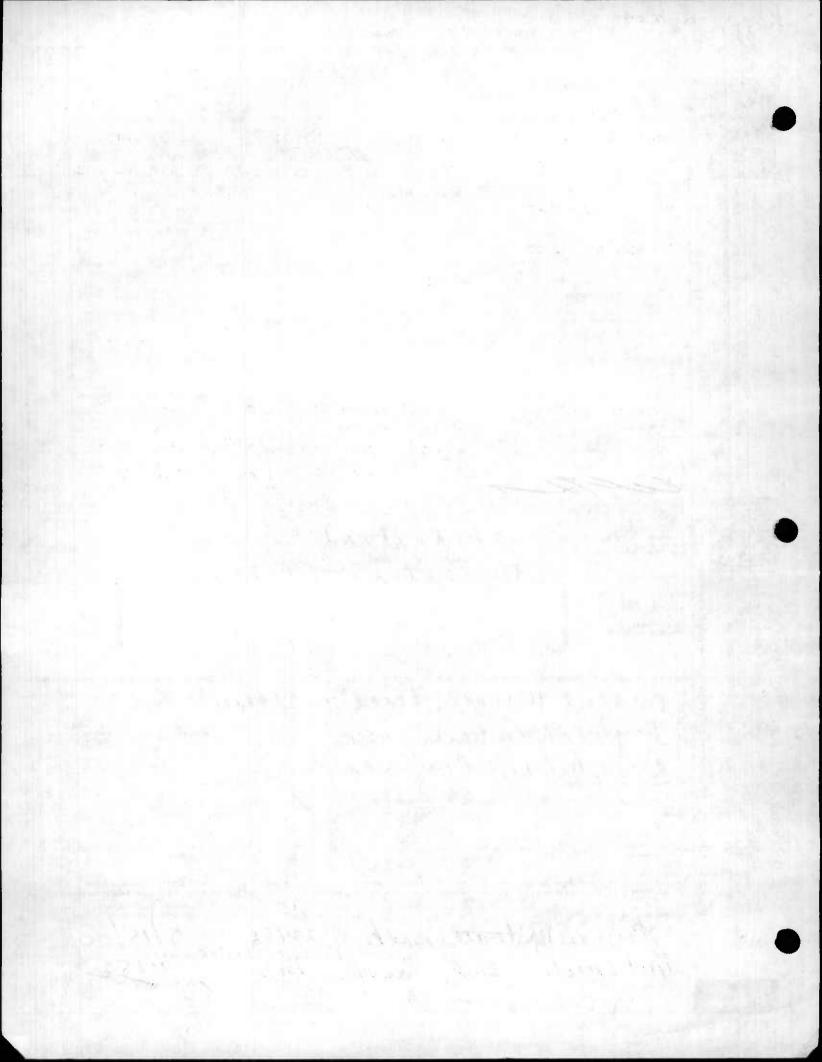
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** MAY 15, 2000 11:30 AM /Medical ROBERT KOPP 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Security Number if Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** Days Months 1 € M 2 □ F 055.05.4177 80 Director AUG 20, 1919 NEW YORK Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD MONTGOMERY SILVER SPRING X Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or items 23a 20901 USA 311 HAMILTON AVENUE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ ENGINEER ELECTRICAL permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked orbh any liquy or other traumatic event 2008. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 FRANK KOPP ROSE JACOBS 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 311 Hamilton Avenue, Silver Spring, Maryland 20901 CHARLOTTE KOPP/WIFE 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 17, 2000 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service Licenses 20852 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physiclan** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ed by the ettending physician and detached for use es the buriel-transit Physician/Medical Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that let the second or the letter of the letter P.O. Box 68760. that initiated events resulting in deeth) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed page 2 should 24a. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To nours efter death.

neral Director: After this y filled in by the funeral di 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 12 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 ☐ Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signeture end title of certified 29c. License number 29d. Dete signed (Month), Dey, Year) V23788 10 Louise M. Stomierowski eted cause of death (Item 23e) (Type, Print) rock ville 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 19 2000

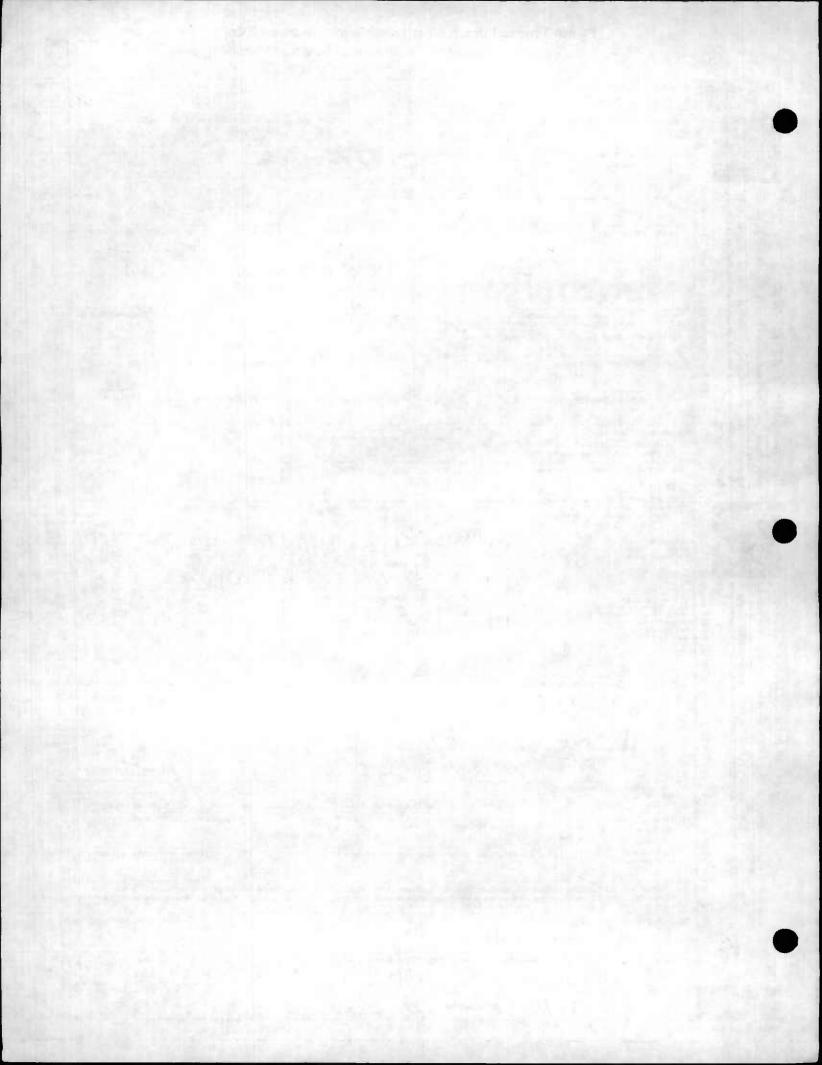
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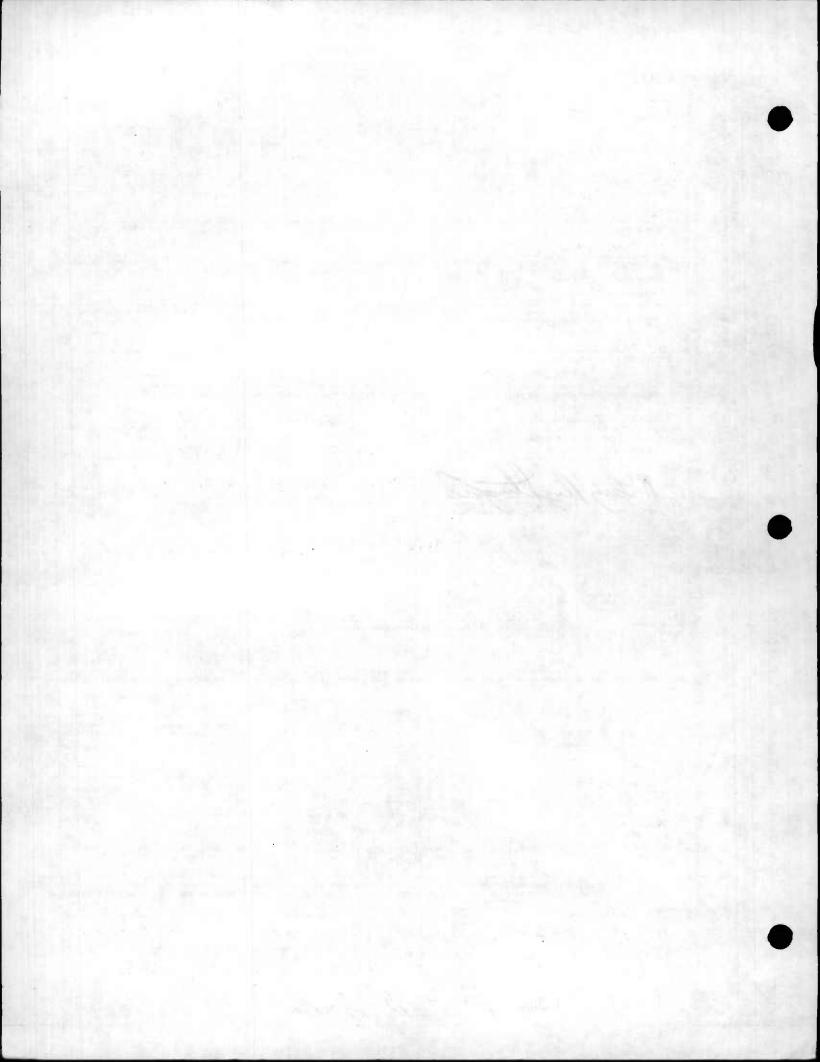
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В	Physician	Decedent's Name (First			1133					2. Dete of Dec Month	Dev	Year	3. Time of Deeth
9	/Medical	Virginia H								May 17			3:52pm
	Examiner	4e Facility Neme (If not in							. City, Town, or Lo			nty of Death	
		Washington							akoma Par		,	gomery	
1	Funeral Director	5. Sociel Security Number 213–12–1373		Sex 7. 1□ M 2 1 F	Age (In yrs. 84	last birthday) Yrs.	If Under 1 Ye Months Da		Hours Min.	8. Dete of Birt (Month, Da Jun 23	1915	9. Birth	piace (Stete or Foreign intry) DC
	aryland	Usual Residence of Deced 10e. State 10b. 0	County		10c. Cit	y, Town or La	eation						10d. Inside City Limits 1 ☐ Yes 2 Ñ No
	Series M		tgome	ry	Sil	ver Sp							
	ufer death with the Ma r fisms 23s or 28s-f s niner must be notified Funeral Director	10e. Street and Number 2201 Colsto	n Dr	#911			10f. Zip Coo 20910				10g. Citizen United		
21215-0020	urs aff., o	11. Meritel Stetus 1 ☐ Never Merried 2(3 ☐ Wildowed 4 ☐ Di		12. Wes Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Dete	es? ≦No		Was Decedent If Yes, specify (1 ☐ Yes 200		panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	E	Reca - Amer Black, White City:Whit	, etc.
2-0	led within 72 ho tyglene. The Medical It, the Medical Completed	15. De	cedent's E	ducation	002/1	16a. Deced	dent's Usuel Oc	cupati	ion	ina	16b. Kind of	Business/Ir	ndustry
21	pple	Elementary/Secondery (ade completed) College (1-4	or 5+)	life.	DO NOT use re	tired)	iring most of work	uig			
21	Non To			4		Physi	cal Edu	cat	cion Teac	cher	Priva	te Sch	1001
9	tal Hy d oth	17. Fether's Name (First, I	Aiddle, Last)				1	18. Mother's Name	e (First, Middle,	Maiden Sum	name)	
<u>la</u>	Ment Ment Ment Ment Ment Ment Ment Ment	George Samu	el Po	pe				I	Lesah Her	nshaw			
an	ohs ohs	19a. Informent's Neme/Re	lationship (Type, Print)		19b. Maiiir	ng Address (Str	reet ar	nd Number or Rura	al Route Numbe	er, City or Tox	wn, State, Zi	ip Code)
Σ	P = 2 = 1	Judith Bast	/ Da	ughter		13408	Parkla	nd	Dr., Roc	ckville	MD 20	0853	
re,	S T He He	20e. Method of Disposition				Plece of Dispo	sition (Neme o	f		Date	20c. Locatio		own, Stete
E C	Page ent c	1 ☐ Burial 2∑☐Crem 4 ☐ Donetion 5 ☐ O			910		e Crema		ry Zi	380 ¹⁹ ,	Beltsv:	ille,	MD
Baltimore, Maryland	Semit. Separtm Mportal Iny inju	21. Signature of Funeral S				Ra	2. Name and Ac	ddress ra.	lot Fecility Cre	emation			
	40144	allocals	like	0)					e Silver	-		0910	
		23a. Part1. Enter the dise shock, or heert tailur	ese, or come. List only	plicetions that cau	sed the deet th line.	h. Do not ent	er the mode of	dying,	, such as cardiec	or respiretory e	rrest,	1	Approximete Interval Between
	Physician			C . 1	116	con.			-10-	-			Onset and Death
N.	/Medical Examiner	Immediate Ceuse (Finel disease or condition		. COI	16E	-7 (1	VE	H I	EART	HAL	JURI	5	1 WZEK
8		resulting In death)				or es a consec			1		-		
٠	icate be executed physician and s the burial-transit edical Examiner			, CO	ROI	NAR	Y AR	-7	ERY	015	EAS	E	5 YEARS
	cate be executed physician and sthe burial-transit	Sequentially list condition:			Due to (d	r as a consec	quence of):		0				
00	ourial vurial	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or Injury that initiated events		A	CUT	ER	ENAL		FALI	URE			1 WEERK
68760,	tificate be execting physician and as the burial-tra	thet initieted events resulting in death) Last		0	Due to (o	r as a conseq	uenca of):				1500		
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30	th ce tend or us			d								1	
	s des	Part II. Other significant c	onditions o	contributing to deal	h but not res	ulting in the u	nderlying cause	giver	n in Pert I.	23b. Dld	tobacco use	contributa	to the cause of death?
9.	es that the death cer igned by the attendin be detached for use by Physician/N	DIAB	616	SME	41-	TUS				10	Yes 2DN	3 □ Pr	obably 4 Unknown
Vital Records, P.O. Box	been s should	ATR	PIAL	FIBI	RILL	ATIO	~				en eutopsy rmed?	8	Vere eutopsy findings svallable prior to completion of cause of deeth?
æ	he la ha age age									10	Yes 2 AN	1	☐ Yes 2☐ No
ta	entifica sctor, p	25. Was case referred to r	nedical						26. Place of Deat	h (Check only o	one)		
	Physician: this certific and director, TO Be (examiner?		Hospital:	atient 2	ER/Outpatier	nt 3C DOA	Other				Other (Snec	nifv)
0	Physical eral	27. Manner of Death		28a. Date of	Injury	28b. Time of	f 28c. I	Injury	at	28d. Describe			
0	th. After		Pending investigation		Dey Year)	Injury		Work1 1 ☐ Y	es 2 No				
Division of	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		Could not be determined	256. Fleca o	Injury - At h		reet, factory, off	ice		28f. Location (: City or To	Street end Nu vn, Stete)	imber or Ru	rel Route Number,
	hours and hours	29a. Certifier 1DC	ertifying Pt	nysician: To the be	est of my kno	wiedge, deeti	occurred et th	e time	e, date and pieca,	and due to the	ceuse(s) and	menner es	stated.
	in 24 hour he Fune pletaly fil	one) 2 M	porcei EXM	ninsr: On the basi and manne		aon and/or in	vastigation, in n	пу орн	THOM, GEETH OCCUP	ou at the time,		~	
	To the trop	29b. Signeture end title of	certifier	1	H 0	01	29c. Lic	ense	number		29d. Date sig		
•	0	VIS	M	7	land	. 1 29	5	0	1787 1		5. 1	F.0	0
	D	30. Name and address of	person who	completed cause	of deeth (Item		Print) JOVER	2	PKWY	GRE	25N1	BEL	~ MD 25770
	State	31. Dete filed (Month, Dey	Year)	32. Rec	istrar's Signe	11.44	1	,					
	Registrar	IU/IV	1 4 /	100 17 1 / 100		1-7	1100	4					



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	State of Maryland / Department of Health and Certificate of Death	Mental Hygiene Reg. No.	0 17326
Physicia /Medica	Decedent's Name (First, Middle, Last) CAROL ANN ELIZABETH KNOPP	2. Date of Death Month May 9 Day 2	3. Time of Deeth Year 8:47 pm
Examine	4a Facility Name (If not Institution, give street and number) 4b. City, Town, or University of Maryland Medical System Baltin	nore N/	
Funeral Director	5. Social Security Number 217-62-6311 6. Sex 1		Birthplace (State or Foreign Country) MARYLAND
D .	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Asryla ad at			1 ☐ Yes 2 X No
or 28sf s	10e. Street and Number 10f. Zip Code	10g. Citizen of	
The will		USA	What oddiny i
5-UUZU 72 hours after death with the Maryls natural, or items 23s or 28s-f sho dical Examiner must be notified at	11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 ☑ Married 11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes ② □ No	Specify Yes or No- 14. Red	ce - American Indien, ck, White, etc. y: WHITE
72 hours mature		orking 16b. Kind of B	usiness/Industry
Maryland 21215-0020 of 2 should be filed within 72 hours at th and Mental Hygiene. 77 is merised other than "natural", or traumatic event, the Medical Exam	Elementary/Secondery (0-12) College (1-4or 5+) 1 2 STOCK ROOM CLER		STORE
tal the	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	ame (First, Middle, Maiden Surnar	ne)
Mental be Mental be with the several series of the series of the several series of the s	RAYMOND MONROE UTZ FLORE	INCE BARNES	5
and	19a. Informent's Neme/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or F	Rural Route Number, City or Town	, State, Zip Code)
	RUSSELL J. KNOPP -HUSBAND 724 GORSUCH RD., W	ESTMINSTER, N	MD. 21157
of the control of the	20a. Method of Disposition 20b. Plece of Disposition (Nama of cemetery, crematory or other place)	Dete 20c. Location	City or Town, State
Pages Nent of the first of any or o	1 U Buriai 2 M Cremation 3 U Removat from State	/11/00 BALTIM	ORF MD
pamil. Pages 1 a Department of Hea Important: If Nem any injury or othe any injury or othe	21. Signature of Funeral Service Licensee 22. Name and Address of Facility FT 254 E. MAIN ST.	LETCHER FUNER	AL HOME
, Physician	23a. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardia shock, or hear feilure. List only one ceuse on each line.		Approximate Interval Batwaan Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition a Stroke resulting in death)		
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cate be executed physician and the burial-transit	Ceuse (Disease or trijury		
ath certificate be exattending physician for use as the burial	that initiated events resulting in death) Last Due to (or es a consequence of):		t
at the death certification of the standing letached for use a	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use co	entribute to the cause of death?
es that the death certigned by the attendin		1 ☐ Yes 2 ☐ No	3 Probably 4 N Unknown
aw requir		24a. Was an autopsy performed?	24b. Ware eutopsy findings avellable prtor to completion of cause of death?
The law ate has page 2		1 ☐ Yes 2 No	1 Yes 2 No
	25. Was case referred to medical 26. Place of Dr	eath (Check only one)	
Physician: rthis certific	examiner? 1 Yes 2 No	Home 5 ☐ Residence 8 ☐Ott	her (Specify)
or Attending Physician: T after deeth. Director: After this certificat d in by the funeral director, po	27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Data of trijury (Month, Day Year) 28b. Time of finjury at Work? 1 Yas 2 No	28d. Describe how injury occu	rred
Lal or Attending P rs after death. al Director: After t led in by the funera	3 Suicide 4 Homicida 6 Could not be datermined 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify)	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place (Check only one) 2 Medicat Examinar: On the best of my knowledge, deeth occurred at the time, date and place and menner stated.		
To the To the comp	29b. Signature and the of certifies 29c. License number P11515		ed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	timore, MD 21	201
State Registra	31. Dete filed (Month, Day, Year) MAY 15 2000 32. Registrar's Signature A Spark	,	
	- Love y popular		

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yaar **Physician** Barbara Lorraine Lee 17 2000 12:55 AM May /Medical 4a Facility Name (If not institution, give streat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 9,1928 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2ÑF Months Deys 72 Yrs 217-24-9429 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 ☐ Yes 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Nerna 23a 511 Wilson Road 21401 USA Funeral iel Hygiena. d other than "netural", or flema event, the Medical Examiner or 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Deputy Register of Wills Anne Arundel County Saitimore, Maryland permit. Peges 1 and 2 should be file Departmant of Health end Mentel Hy, Important: If flem 27 is marked other important or other traumatic event. Dates. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert H. Lamb Edna Norwood 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) John W. Lee / husband 511 Wilson Road Annapolis, MD, 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ABurlal 2 Cremation 3 Removal from State Hillcrest Cemetery 5-20-00 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD, 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service License 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Aspivation pneumouia Sdays tmmediate Cause (Finet disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown veual 1 Yes be del Records, by 24b. Were autopsy tindings available prior to completion of causa ot deeth? Completed paga 2 should 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Invastigation To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. complately (Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 019838 29d. Date signed (Month, Day, Year) 29b. Signature and fitte of certifier louillus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O Bestgate Annapolis, Md. 21401

State Registrar 31. Date filed (Month, Day, Year) MAY 1 9 2000

Stuaut

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Amend Item#2 HCHD 5/23/00 bh Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death May 7 200 6. Time of Death Physician Josephine (nmn) March 7,000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford Hours Min. 8. Data of Birth (Month, Day Year)
ADTIL 25,1924 If Under 1 Year 5. Sociel Sacurity Number 6. Sax Birthplaca (State or Foreign Country)
 Virginia 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Months Days 230-28-5560 76 Yrs. Director Usual Rasidance of Decedant 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yas 2 No Directo Maryland Harford Bel Air 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 11 S Atwood Rd. 21014 IISA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑No If Yas, Giva Yaar or Datas: Heme Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marilal Status permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Important if them 37 is marked other than "natural", or than any injury or other traumatic event, the interest, or than any injury or other traumatic event, the interest. Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 √Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 Quality Control Inspector Glass Manufacturing 17. Fethar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surneme) Anna (u/k) Dertha Sam (u/k) Thomas 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2303 Carlo Rd., Fallston, MD 21047 Donna A. Grocott/ Daughter 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Byrial 2 Cramation 3 Removal from Stata onation 5 Other (Specify) Memorial Gardens 5-10-00 Bel Air, Maryland ature of Funeral 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, list only one ceusa on each line. Approximata Intervel Between Onset and Death **Physician** Immediate Causa (Final diseesa or condition rasulting in deeth) /Medical EPSIS WEEK Examiner Due to (or as a consequence of): Examiner HEUMONIA weck physician and s the burial-trensit Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disaasa or injury Due to (or es a consequence of): GANGRENE 2 weeks Box 68760. DF LEGS Physician/Medical that initiated evants rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? by the 1 Yes 2 No 3 Probably 4 Unknown LANSIENEP signed b þ 24b. Wara autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy Completed 27 HEIMENS MEMENTON 1 ☐ Yes → No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 89 25. Was case raferred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 200 No Certification: To Division of this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Invastigation death. 1 Yes 2 No 2 Accident hours after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 2 4 Homicide hin 24 hours aff the Funeral Di mpletely filled Ir I ☐ Carallying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

☐ Medical Examiner: On the basis of examination and/or investination in any ocioios, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 29a. Certifiar edical (Check only one)

State Registrar 31. Data filed (Month, Day, Year) MAY 1 0 2000

PHILLIPS

29b. Signatura and Ala of culture

32. Registrar's Signatura

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

2005

III Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

22843

29d. Dete signed (Month, Day, Year)

GOOD

21050

29c. License number

NA

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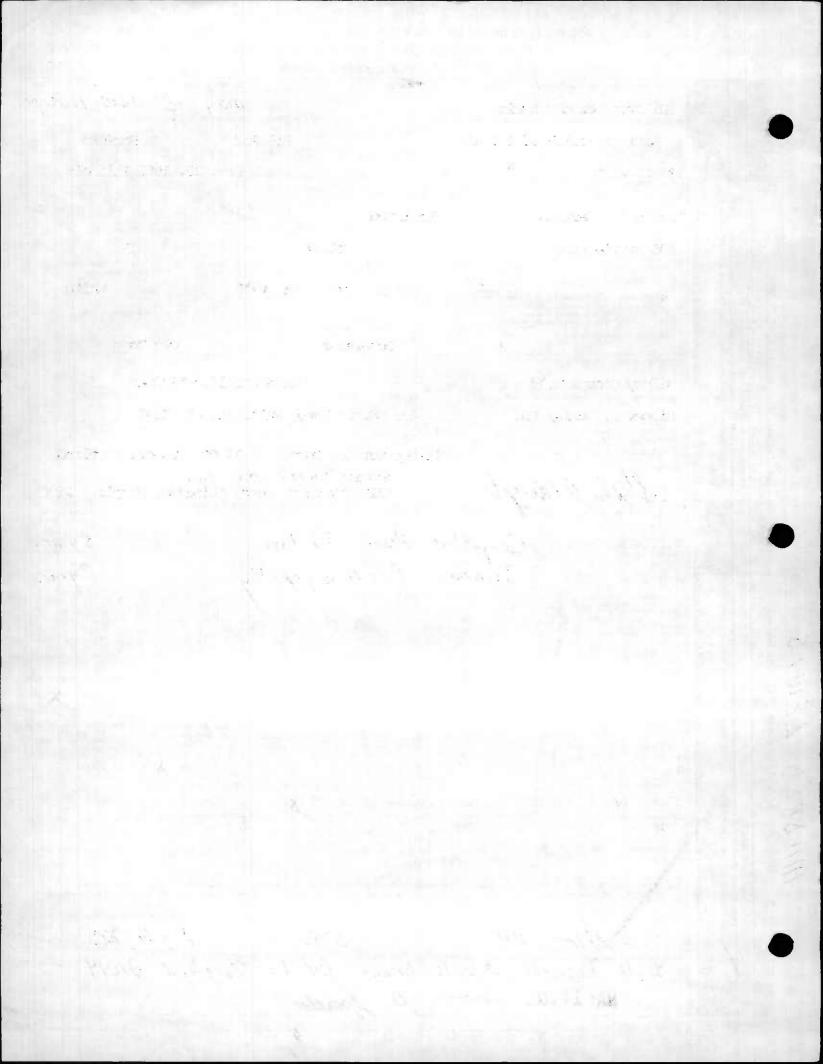
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

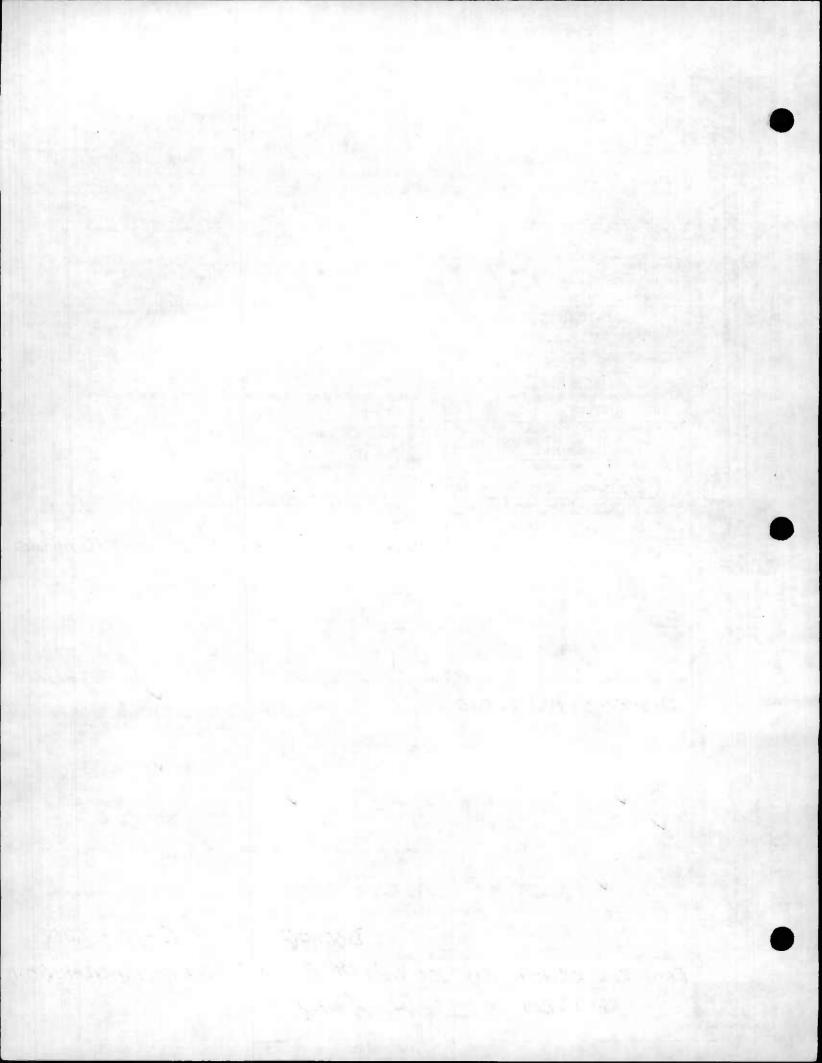
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dical	Mildre	d Doroth	ny Lewis					ma			2000	
iner	4a Facility Name	(If not institution,	give street and num	nber)			4b. City, Town	, or Location of	Death	4c. County	of Death	
	Marin	er Healt	th of Bel	Air			Be1	LAir			Harfo	ord
٦	5. Social Security		6. Sex	7. Age (In yrs. las		Under 1 Year	r if Under 24		of Birth		9. Birth	piace (State or Fo
	339-20-8	150	1□M 2√2F	98	Yrs.	lonths Days	s Hours	Min. (Mon	25	, 1901	T11	inois
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ľ	10a. State	10b. County		10c. City, T	Town or Locati	ion						10d. inside City L
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	11. Marital Status		12. Was Dece Armed For	dent Ever in U,S.	13. Was	s Decedent of es, specify Cul	Hispanic Orlgin ban, Maxican, F	n? (Specify Yes Puarto Rican, e	or No-		ce - Ameri ck, White	lcan indian, . etc.
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		15. Decedent	s Education		16a. Decedent	r's Usual Occu	pation		1	6b. Kind of 8	usiness/Ir	ndustry
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		George V						e Carol				
	19a. informant's f	Name/Ralationsh	nip (Typa, Print)		19b. Mailing A	Address (Stree	et and Number o	or Rural Route	Number,	City or Town	, State, Zi	ip Code)
	Sidney	S. Lewis	s/ Son		405 Me	errie I	ane, Fa	allston	, MD	21047		
ĺ	20a. Mathod of Di	sposition		20b. Plac	e of Disposition	on (Name of	laca)	Data	2	Oc. Location	- City or T	Town, State
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State of Maryland / Department of Health and Mental Hygiene 0 0 17330

Physician /Medical Examiner Isabe1 Mae Lakin May 9 2000 7 2000 2000 7 2000 2000 7 2000 200	Time of Death 20 AM (State or Foreign Land Inside City Limits Yes 280 No
Isabel Mae Lakin May 9 2000 7:	(State or Foreign Land
Funeral Director 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De	Land
Funeral Director 5. Social Security Number 213-03-1866 1 M 2015 7. Age (In yrs. last birthday) 78 Yrs. Months Days Hours Min. Jan. 1 1922 9. Birthplace Country) Jan. 1 1922 Mary Just Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Ir MD Frederick Thurmont 10f. Zip Code 10g. Citizen of What Country? 211 Bennett Ct. 12. Wes Decedent Ever in U.S. 13. Wes Decedent Orbital Number 2 14. Race - American In Medical Status 12. Wes Decedent Ever in U.S. 13. Wes Decedent Orbital Number 2 14. Race - American In Medical Status 14. Race - American In Medical Status 15. Race - Am	Land
Director 213-03-1866 1 M 2 F 78 Yrs. Months Days Hours Min. Jan. 1 1922 Susal Residence of Decedent 10a. State 10b. County MD Frederick Thurmont 10f. Zip Code 211 Bennett Ct. 11. Marital Status 12. Wes Decedent Ever in U.S. 13. Wes Decedent Of Hispanic Origin? (Specify Yes or No.) 14. Race - American Inc.	Land
Director 213-03-1866 15 m 125 78 m 15 m 1922 Mary 19 m 1922 Ma	Land
10a. State 10b. County 10c. City, Town or Location 10d. In MD Frederick Thurmont 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 Bennett Ct. 21788 U.S.A. 11. Marital Status 12. Wes Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-	
	L 100 241140
Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.	dian,
1 Never Married 2 Merried 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: White	
15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) 6 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker own home	·
Elementary/Secondery (0-12) College (1-4or 5+) Nomemaker own home	
17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama)	
18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama)	
Carl L. Keeney Grace Mae Beard 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routs Number, City or Town, Stete, Zip Cook	(0)
David L. Lakin - son 211 Bennett Ct., Thurmont, MD 21788	8)
	State
20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Seminary 12 Constitution of Community 12 Constitution of Constitution of Community 12 Constitution of Community 12 Constitution of Constitution	
20e. Method of Disposition 1 Burlal 2 Cramation 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Rocky Hill Cemetery 21. Signature of Truncal Service Licenses 220c. Location - City or Town, Signature of Cemetery, cremetory or other place) Rocky Hill Cemetery 220c. Location - City or Town, Signature of Cemetery 200 Woodsboro, MI 22. Neme end Address of Fecility Hartzler Funeral Home)
21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home	
404 S. Main St., Woodsboro, MD	
23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.	roximete rval Between
Physician Ons	et end Death
Immediate Cause (Fine) Immediate (Fine)	minutes
Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
Dua to (or es a consequence of): Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated avents resulting in deeth) Last Dua to (or es a consequence of):	
Tany, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated avents resulting in deeth) Last Dua to (or as a consequence of):	
Cause (Disease or Injury that initiated avents resulting in deeth) Last Dua to (or as a consequence of):	
A S S S S S S S S S S S S S S S S S S S	
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 250 1	cause of death?
DIABETES MELLITUS	4 ☐ Unknown
\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 1 23b. Did tobacco use contribute to the	utopsy findings le prior to
D & % C/ C	tion of cause h?
	s 2 No
1 Yes 20 No 1 Yes	
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25. Wes case referred to medical examiner? 1 Yes 2 No Hospitel: Impatient 2 ER/Outpetient 3 DoA Other: 4 Mursing Home 5 Residence 8 Other (Specify) 27. Manner of Deeth 1 Netural 2 Accident 3 Suicide 4 Homloide 4 Homloide	ceuse(s)



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State of Maryland / Department of Health and Mental Hygiene 0 1733 |

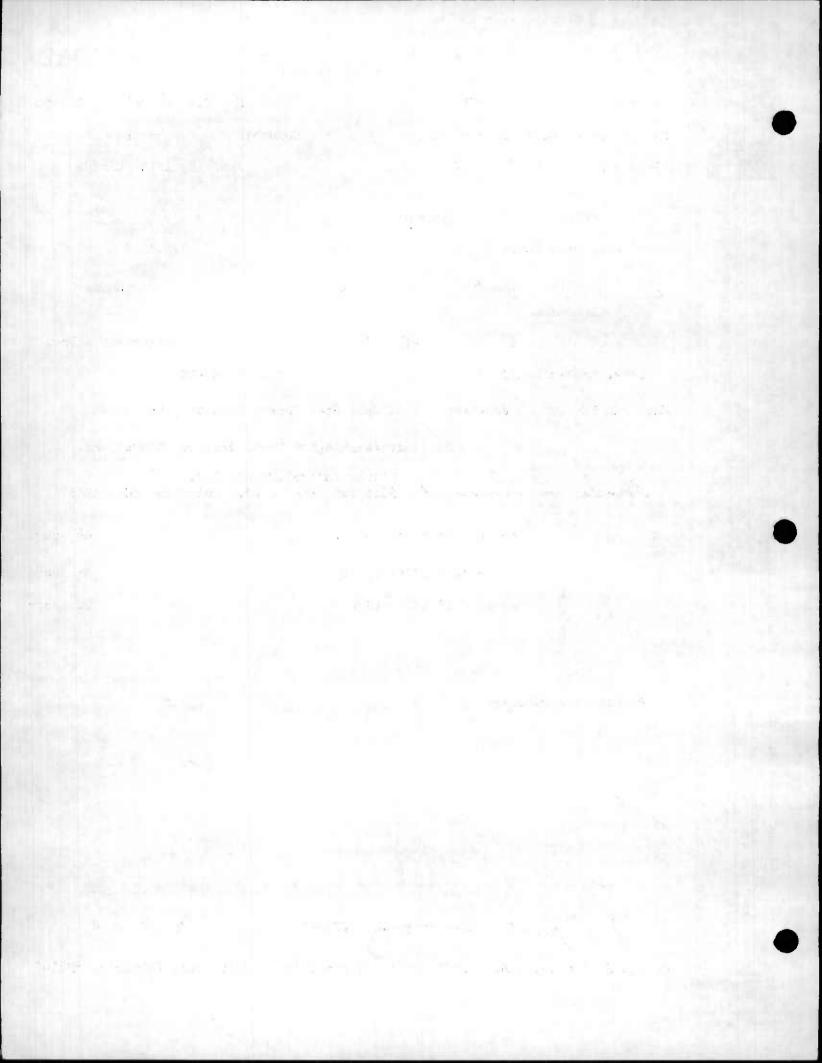
			Ce	rtificate of	Death			Reg. No.		
	1. Decedent's Name (First, Middle, L	est)					2. Date of De Month	ath	Voor	3. Time of Death
Physician /Medical	Ellen Elizal	oeth Lenha:	rt				May	8 200	OO Yeer	4:50PM
Examiner	4a Facility Name (If not institution, gi	ive street end number)			4b. City, To	wn, or Lo	cation of Deat	h 4c. County	of Deeth	
Examine	Citizens Nursin	ng Home			Fred	erick	<	Free	deric	k
Funeval			n yrs. last birthday) If Under 1 Year	r If Under					
Funeral Director		1□M 2X)F	88 Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, De July 1	y, Year) 4 1911	Mai	lace (Stete or Foreign try) ryland
pue M	10a. Stete 10b. County	10	c. City, Town or L	ocation					10	0d. Inside City Limits
within 72 hours after death with the Maryland ena. than "natural", or itema 23a or 28a-f show he Midical Exeminar must be notified at smpleted by Funeral Director			WAlkersv:							1 ☐ Yes 2 🛣 No
in the state of th	10e. Street and Number			10f, Zip Code				10g. Citizen of V	Vhat Coun	try?
hwing 23a	8410 E Lassie Ct	.		2179	93			U.S.A	•	
after death with the More than 23e or 28e-finance and the motific of Funeral Directo	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U,S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Or	igin? (Spe	cify Yes or No		e - America	
취 표면 교	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No		The second second			rican, etc.)	Blac	ck, White, e	etc.
by	3 ☐ Widowed 4 ☐ Divorced	It Yes, Give Year or Dates:	35-11	1□ Yes 2☑ No	Specify:			Specify	Wh	ite
ed within 72 hours ygiene. The matural, of, the Medical Exe Completed by	15. Decedent's E		16a. Dece	edent's Usual Occu	pation			16b. Kind of Bu		
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than the	Elementary/Secondary (0-12)	College (1-4or 5+)	re	gistered	nurse			hospita	a1	
al Hygiena. I other than went, me Me	17. Father's Name (First, Middle, Las	0	1 10,	BIDGET CU	1		(First Middle	Maiden Sumem		
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Men I						-				
permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Ison 27 Is marked other any Injury or other traumatic avent, once. To Be C	19a. informant's Name/Relationship			ing Address (Stree						
and palith	Glenn H. Lenhart	Sr husb	and 8410	O E Lassi	e Ct.	, Wal	lkersvi	lle, MD	217	93
T F F	20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Neme of ematory or other pla	ace)	M	ay 11	20c. Location -	City or To	wn, State
Page ent	1 ☑ Burlal 2 ☐ Cremation 3 [4 ☐ Dogetion 5 ☐ Other (Speci			Cemeter			2000	Woodsb	oro	MD
in mine	21. Signature of Fugeral Service Lice			2. Neme and Addr	-	thu				
Depa Impo any I	1 (Thring	() X6.72	len			Ha	artzler	Funera:	1 Hom	e
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	23a. Part1. Enter the disease, or con shock, or heart teilure. List only	nplications that caused the	deeth. Do not er	nter the mode of dy	ing, such es	cardiac o	r respiratory a	rrest,		Approximate Intervel Between
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Examiner	resulting In death)	a		_		4 -101	1		-	1. 3.
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ficate be executed physician and is the burial-transit	The second second second	b							1	
artificate be executed ting physician and se as the burial-transit	Sequentially list conditions, if any, leeding to immediate	Due	to (or as e conse	quenca ot):						
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dic the	that initieted events resulting in death) Last	Due	to (or as a conse	quenca ot):					i	
U (0)										
eath certification attending part of for use as iclan/Me		U.							1	LEC STORY
0 0 0	Part II. Other algnificant conditions	contributing to death but no	ot resulting in the	underlying cause g	iven in Part	1.	23b. Did	tobacco une cor	ntribute to	the cause of death
ed by the detache							10	Yea 2000	3 ☐ Prob	ably 4□ Unknow
be de Dy P									- 4	
requires seen sign should be							24a. Was	an autopsy	24b. We	ere autopsy tindings
been si should leted								ormed?	cor	ailable prior to mpletion of cause
has b									ot c	death?
cate has been s page 2 should	of the second states of the						10	Yes 2 No	10	Yes 2□ No
certificate rector, pag	25. Wes case reterred to medical		The same		26. Place	e of Death	(Check only	one)		
	examiner?	Hospital:	2 ER/Outpetie	ent 3 DOA OI	than			denca 6 Oth	er (Specifi	v)
Physical distriction	27. Manner of Deeth	28a. Date of Injury	28b. Time o					how injury occur		//
Affe fund	1 Accident 5 Pending investigation	(Month, Dey Ye	nar) injury		ork?]Yes 2.∐	No				
Attending or death. or death. or the fune by the fune fune fill cation.	2 Accident investigetic	200	****				10t Leasties /	Ctood and Mumb	as as Ours	I Coute Number
after d Direc I in by	4 Homicide determined	28e. Place of Injury building, etc. (S	At nome, tarm, s Specify)	treet, factory, office	,	-	City or To	Street end Numb wn, Stete)	er or mura	r Hobre Number,
tal or Attending P is after death. al Director: After t led in by the funers Certification:										
To the Heeplal or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification.	29a. Certifier Check only one)	hysician: To the best of m miner: On the basis of exa and menner steted	mination end/or in	th occurred at the to execute the total the to	ime, date en opinion, des	nd place, a ath occurre	and due to the ed at the time,	cause(s) and ma date and place,	inner as st and due to	ated. the ceuse(s)
Me the	29b. Signature and title of certifier			29c Licen	ise number			29d. Date signe	d (Month	Dev. Year)
F 3 F 8	255. Organizate and this of certified	1)				
	Muchil	uni		100	3/01	1		May 9), 20	00
	30. Name and address of person who	completed cause of death	(Item 23e) (Type	, Print)						
	Gene F. Ashe	Wood	sboro Me	dical Ct	r.	Wood	sboro,	MD 2179	8	
State	31. Date filed (Month, Day, Year)	32. Registrer's		, ,			,			
Registrar	MAY 11	2000 Sene	va &	Som	K					
J				/ /	-					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 17332

					Cert	ificate of	Death	F	leg. No.		1336
Physician	ı	1. Decedent's Name (First, Middle, L Muriel Rober		nt				2. Date of Dea Month May 8,		O O O	3. Time of Dec 2:41pt
/Medical Examiner		4a. Facility Neme (If not institution, g Howard County (4b. City, Town, or L	ocation of Death	4c. County	of Death	2.41p
Funeral Director				ge (In yrs. last i	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 1	Year) 1916	9. Birthpia Count Cana	ace (State or Fo ny) ada
show		10a. State 10b. County		10c. City, To	wn or Loca	ation				10	d. Inside City L
death with the Maryland ms 23a or 28a-f show rmust be notified at		Md. Howard		Colu	mbia	10f. Zip Code			10g. Citizen of \	What Count	1 ☐ Yea 2 F
or ita	Dy ruileiai	9643 Cold Star 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forces	?		21046 as Dacedent of Yes, specify Cut	Hispanic Origin? (Sp an, Mexican, Puarto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - America ck, White, e	tc.
"natur	ופופת	15. Decadent's l (Specify only highest g	Education rade completed)	16	e. Decede	nt's Usuel Occu	pation during most of worked)	ing	16b, Kind of Bi	usiness/Ind	ustry
giene.	5	Elementary/Secondary (0-12)	College (1-4or	5+)	libra				eleme:	ntary	school
Mental Hy Mental Hy arked oth atic event		17. Father's Name (First, Middle, Las Peter Robert	,				18. Mother's Nam Margar			na)	
alth end A 27 is ma r trauma		19a. Informant's Name/Relationship Mary Ann Levant			-		and Numbar or Rur ar Court,				,
permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Monce. To Be Comp		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Spec		came	tery, crema	tion (Nama of htory or other pla /Washin	gton Crem		20c. Location -		
Physician /Medical =xaminer Examiner		23a. Part1. Enter tha disease, or conshock, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	conges a. ischer		eart consequence consequence diomy	failure ence of): copathy ence of):	Kno11s R	d., Colu	imbia, N		Approximate inderval Betwee Onset and Dea 48 hou: 48 hou: 72 hou
requires that the beant certificate the executed the signed by the ettending physician and hould be detached for use as the burial-trensit attended by Physician/Medical Examir		Part II. Other significant conditions		Due to (or as a			ven in Part I.		obacco use co		the cause of da
		Parkinson's	Disease					24a. Wes a	an eutopsy	24b. Wer ava corr	re autopsy findi lleble prior to apletion of caus eath?
is certificate has be director, page 2 s								1,24	es 2 No	10	Yes 2 No
this certific ral director,		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospitai:	ent 2□ER/0	Outpatient	3□ DOA Ot	26. Place of Deat her: 4□ Nursing Ho	h <i>(Check only or</i> ome 5 ☐ Resid		er (Specify)
After fune		27. Manner of Deeth 1 Naturel 5 Pending 2 Accident 5 Pending investigati	28e. Date of Inju (Month, De	ay Year) 28b	. Time of Injury		ny at vrk? I Yes 2 No	28d. Dascribe h			Route Number,
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within 24 hours or to the Funeral I completely filled		(Check only 2 Medical Exa	miner: On the basis o and mannar st	f axamination a	nd/or inve	stigation, in my	opinion, death occur	red at the time, o	lete and pleca,	end due to	the ceuse(s)
		29b. Signature and title of certifier	even		ti	29c, Lican D34		2	May 10		
10		30. Name end address of person who George S. Groma					nt Pkwy	Suite 10	01, Col	umbia	, MD210
State Registrar		31. Dete filed (Month, Day, Year) MAY 16		rar's Signature	6	loa	4.1				

DHMH 16 Rev 6/95



Amended #20b, NLS, 5/18/00, Allegany Co.

Please Type or Print In Black indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** MAYETTA I. LIPSCOMB 16, May 2000 3:00 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL & MEDICAL CENTER Cumberland Allegany Hours Min. SEPT. 30,1930 WEST VIRGINIA If Undar 1 Yaar 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days Months 1 M 2 TF 232-66-1548 69 Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or frama 23s or 28s-f show other treumetic avent, the Medical Examinar must be notified at MD ALLEGANY CUMBERLAND Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21502 U.S.A. 127 GLEASON STREET Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. hours efter 1 Yes 2 If Yes, Give 1 Never Married 2 Married 21 No altimore, Maryland 21215-0020 1 Yas 2♥ No Specify. Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) CHILD CARE SELF-EMPLPOYED 6 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 end 2 should be file Department of Health and Mental Hy Important: if Nem 27 Ia marked oth any Injury or other treumatic avent 17. Father's Name (First, Middla, Last) Be SEYMORE BLAINE CARR MABEL VARNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 127 GLEASON STREET, CUMBERLAND, MD 21502 WAYNE LIPSCOMB / HUSBAND 20b. Place of Disposition (Nama of cemetery, crematory or other place) 5/18/c 20a. Method of Disposition 20c. Location - City or Town, State 00 I ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CUMBERLAND, MD HILLCREST BURIAL PARK 4 Donation 5 □ Other (Specify) 21. Signature of Funaral Servica Licensee 22. Nama and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last the burial-tran and physician VO cal Box 68760 certificate be Physician/Medical Due to (or as a consequence of) 88 980 P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 16 3 Probably 4 Unknown Records, by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed peeu 188 1 Yes 20 HO 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was casa referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) P 1 Yes 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) edicai Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicida 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide ying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

It is a fical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 D0054426 May 2000 30. Name and address of person who completed aute of death (Item 23a) (Type, Print) YU Hospital Medical Bldg. 105, Cumberland, MD Dr. Michael D. Zang Memorial 21502 31. Date filed (Month) 7 1 8 2000 32. Registrar's Signature State Registrar

MIN BELAM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () ()

Certificate of Death

-		Decedent's Nama (First, Mid	rile (act)		061	lineale C	n Dea		2. Data of D	Reg. No.		3. Time of Death
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	Examiner	4a Facility Nema (If not institut ALLEGANY COUNTY						, Town, or L BERLA	ocation of Dea		y of Death LEGAL	
	Funeral Director	5. Social Sacurity Number 214-07-3111	6. Sax 1 M 2 □ F	7. Aga (In yrs. 85	last birthday) Yrs.	If Undar 1 You Months Da		dar 24 Hrs. Irs Min.	8. Deta of E (Month, I	Birth Dey, Yaar) 1, 1914	Col	nplace (Stata or Foreig untry) YLAND
	D >	Usual Rasidanca of Decedant 10a. Stata 10b. Coun		100 Cib	y, Town or Lo	antion						10d. Insida City Limits
	e Maryla		MPSHIRE		PRINGE							1 ☐ Yes 2 No
	h with the Ma 13a or 28a-f e	10e. Street end Number route 1				10f. Zip Coo				10g. Citizan of U.S		untry?
020	72 hours after death with the Maryland natural", or ferms 23a or 28a-f show deal Examiner must be neutral at	3 □ Widowed 4 □ Divorce	arried 1 1 Yas	cedent Ever in U, orcas? 2 No iva WW]		Was Decedant f Yes, specify (1 ☐ Yas 2 ☑	uban, Max	lcen, Puart	pacify Yas or f o Rican, atc.)	BI	ack, White	
0	"natural",	15. Deced	ent's Educetion		16a. Deced	dant's Usual Oc kind of work do	cupation	most of use	deina	16b. Kind of	Business/I	industry
21215-0020	c ' 최 중	Elamantary/Secondary (0-12	east grada completad, Collega	(1-4or 5+)	lifa. I	RY WORK	tired)	nost of wor	King	CELANE		
	be filed tall Hyger and other swent,	17. Fether's Neme (First, Middl	a, Last)				18. M	other's Nan	na (First, Midd	la, Maidan Suma	ma)	
Maryland	should be filed and Mental Hygi merked other ametic event, To Be Co	HUFFMAN LLE	VELLYN				MY	RTLE	MCLANE	MCKENZI	E	
any	should and Mer marks umartic	19a. Informant's Name/Ralatio	nship (Type, Print)		19b. Meilir	ng Addrass (St	aat and Nu	imbar or Ru	ral Routa Num	ber, City or Tow	n, Stata, Z	(ip Coda)
	1 and 2 a Health ar em 27 le other treu	GEORGIANNA V.	LEWELLYN	/ WIFE	P.0	O. BOX	245 -	SPRI	NGFIEL	D, WV 2	6763	
Baltimore,	ages ent of it: If it y or c	20a. Method of Disposition 1 対 Buriel 2 ☐ Crametion 4 ☐ Donation 5 ☐ Other		0	ematary, crar	sition (Nama o natory or other LD HILL	placa)	TERY	Data 5/18/00	20c. Location SPRING	-	
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of	2 2 7	27. Mennar of Death	28a. Data	of Injury	28b. Tima o		njury at Work?	a Nursing P	T	e how injury occ		my)
Division	tal or Attending Physicien: rs after death. el Director: After this certific led in by the funeral director, Certification: To Be (3 ☐ Suicida 6 ☐ Coul	d not be	e of Injury - At ho	Injury	М	1 Yas	2 🗆 No	28f. Location	(Street and Nun	nber or Ru	ural Route Number,
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	MAS	30. Nama and addrass of person	n wire complated cau	isa of death (Item	n 23a) (Type,	Print) Road	1110	about	and W	in Si	502	

Spark

State

Registrar

March & March

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 17335

						Ce	rtificate	e of	Death			Reg. No.		
		1. Decedent'a Nem	e (First, Middle, La	st)							2. Dete of De Month		Year	3. Time of Death
	Physician /Medical	Eldred C	oughenour	Leiste	er						May 15	Day 200		8:30 P.M.
$\lambda -$	Examiner	4a Facility Name (If not institution, giv	e street end nu	m <i>ber</i>)				4b. City, To	wn, or Lo	cation of Deet		nty of Deeth	
		Sacred He	eart Hosp	ital					Cumbe				legany	
	Funeral Director	5. Sociel Security N 215 14 64 Usual Rasidance o	106	M 2□ F	7. Aga (In y	rs. last birthday, Yrs.	If Under Months	1 Yaar Deys	If Under Hours	24 Hrs. Min.	8. Data of Bir (Month, Da 10~03~	th y, Year) 1920	9. Birth	placa (State or Foreign ntry)
	8=	10e. Stete	10b. County		10c.	City, Town or L	ocation			-,				10d. Inside City Limits
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1	rec post	10e. Street and Nu	mber				10f. Zip	Code				10g. Citizen	of Whet Cou	ntry?
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ind 21215-0020	Health and Mental Hyghen. The the narked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Esseriner must be notified at other treumstic event, the Medical Esseriner must be notified at To Be Completed by Funeral Director	11. Maritai Status 1 ☐ Never Merr 3 ☐ Widowed	ied 2 (X) Merried 4 Divorced	12. Wes Dec Armed Fo 1 Tas If Yas, Gir Yeer or D	2V No	n U,S. 13.	Was Deced if Yes, spec 1 ☐ Yes		lispenic Ori en, Mexicei Specify:		ecify Yes or No Rican, etc.)		Raca - Americ Bleck, White, acity: Wh	
2	hygiene. her than "naturi nt, the Medical I	/Sner	15. Decedent's Ed	ducetion	984	16a. Dece	dent's Usua	i Occup	ation	et of worki	ina	16b. Kind o	f Business/In	dustry
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-	xaminer	resulting in death)			que to	or as e conse	uence of):							dixlos
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	d by the attendiateched for use	Pert II. Other signit	icant conditions of	d ontributing to d	eath but not	rasulting in tha	indertvina c	euse giv	ven in Pert	t,	23b. Did	tobacco uee	contribute t	o the ceuse of deeth?
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Division of	rs after death. al Director: Aftar this cartificated in by the funaral director, Certification: To Be (4 ☐ Homicida	determined	28a. Piace buildi	of injury - A ing, etc. (Spe	it homa, farm, si scify)	raat, fectory	, office			City or To		um <i>ber or Hur</i>	el Route Number,
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2	n 24 hound ne Funda plately fil edical	(Check only one)	13 Certifying Ph 2 Medical Exam	niner: On the b	asis of exam	inetion end/or in	vestigetion,	, in my o	ppinion, das	ath occurr	red at tha time,	date end pte	ce, and dua	to the cause(s)
	within 24 hours after of To the Funeral Direct complately filled in by Medical Certifile	29b. Signeture end	title of curtain,	11	N.A.	7	290	. Licens	se number			29d. Date sig	gned (Month,	Day, Year)
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		30. Neme end eddr	ess of person who	completed cause	se of deeth (Item 23a) (Type	Print)	JOV.	210			May	14	2000
	nos	Juno A	Arragine	no a	02	Seton	-	10.	Cun	nber	land,	C am	1502	
	State	31. Date filed (Mon			Registrar's Si	gnafura 6	-	Ks						
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 12, 2000 3:00 PM Maka Larsen-Basse /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6200 Pertshire Court Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 M 2 M F Yes 340-30-9944 Director 65 August 3, 1934 Illinois Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location worde 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or offer traumatic avent, the Medical Empirical must be notified an any injury or offer traumatic avent, the Medical Empirical must be notified an any injury or offer traumatic avent. Maryland Montgomery Bethesda 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6200 Pertshire Court 20817 United States Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify. ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Anthropologist University 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold M. Simpson 2 Carmen Perez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jorn Larsen-Basse/ Husband 6200 Pertshire Court, Bethesda, Maryland 20817 Date 15, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2000 Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 21. Signature of Funerel Service Co M00689 Bethesda, Maryland 20814-3501 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical 10 Months Metastatic Colon Cancer Examiner Due to (or as a consequence of) Examiner sloian and bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): signed by the aid to be detached for P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one)

certificate Division of Vital Attending Physician: funeral director, this After death. a 24 hours efter death we Funeral Director: A pletely filled in by the f

B Certification: To

1 ☐ Yes 2 X No

5 Pending investigation

27. Manner of Death

1 X Natural

2 Accident

To the Hosp within 24 hos To the Fune completely fi 20 Medicai

6 Hospital

6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end menner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

28c. Injury at Work?

1 TYes 2 □ No

MD 31362

Other: 4 Nursing Home 5 \ Residence 6 Other (Specify)

28d. Describe how injury occurred

May 15, 2000

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

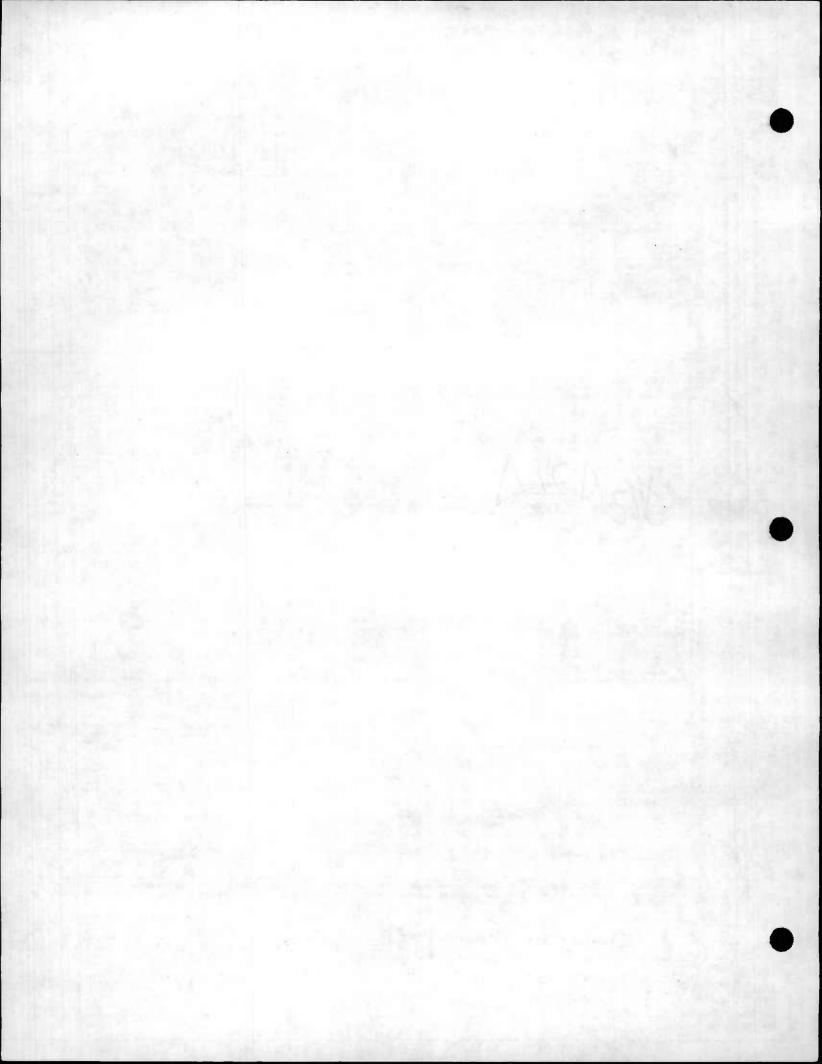
New Mexico Avenue N.W. #348 Washington, D.C. 20016-3622 3301 Linda Yau, M.D.

State Registrar 31. Date filed (Month, Day, Year) MAY 17

32 Facistrar's Signature socks

1 inpatient 2 ER/Outpatient 3 DOA

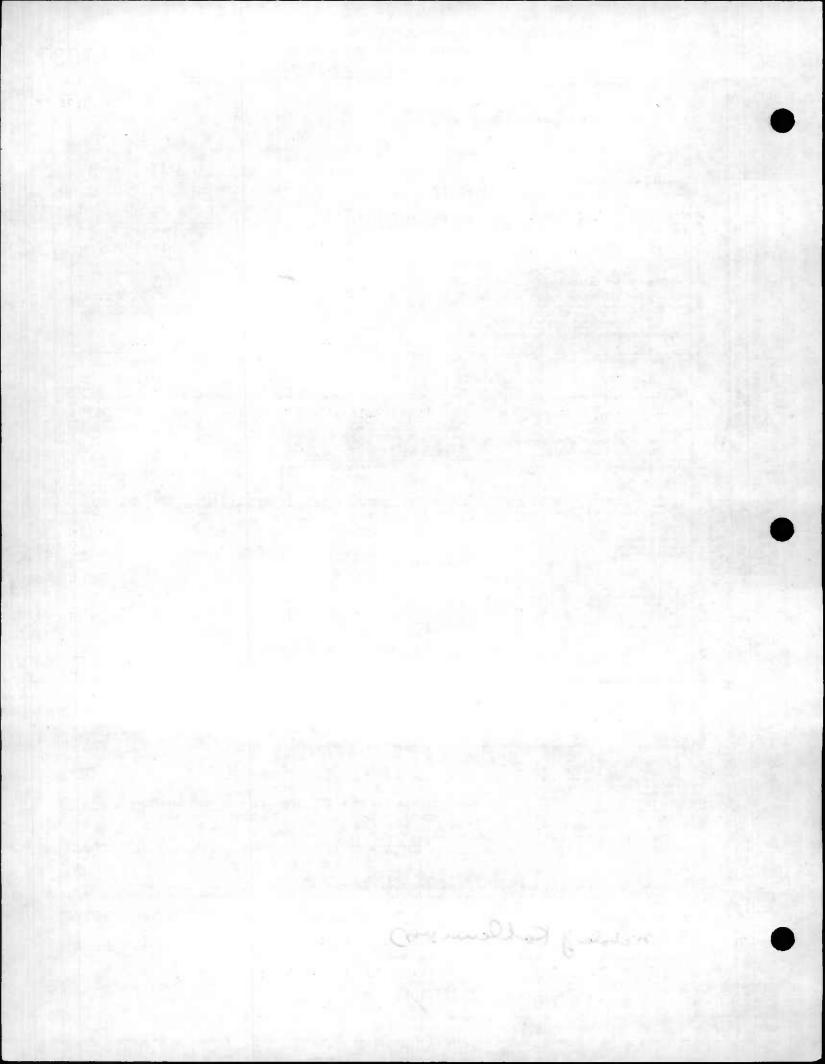
28b. Time of



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Yaar **Physician** Anna Lisa Larson May 16, 2000 3:45 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Shady Grove Nursing Center Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2□ F 86 Yrs. 199-36-7964 May 18, 1913 Director Sweden Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits parmit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Mayden Department of Hastin and Mentel Hygiene. Important: If them 23 a or 28 a february important: If them 27 is marked other than "natural", or ferms 28 or 28 a february injury or palver traumatic event, the Medical Exemples must be notified at anota. 1 ☐ Yas 2 ☐ No Directo Maryland | Montgomery Darnestown 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 15636 Haddonfield Way 20878 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10 Homemaker 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) 8 Anna Johannson Albert Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 15636 Haddonfield Way, Darnestown, MD 20878 Gus Larson, Husband saltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal treff State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Nama of cemetary, crematory or other place) Data 20c. Location - City or Town, State May 17 Metropolitan Crematory 2000 Alexandria, Virginia 21. Signature of Furjeral Service Lio 22. Nama and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 eucy 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock or heart feilure. Approximata Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pneumonia 24 Hours Examiner Due to (or as e consequence of): **Immobility** @ 3 Months physicien end a the burlei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Severe Osteoarthritis Years Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by th detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Ischemic peripheral vascular disease signed d be del à 24b. Wera eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Hypertension Congestive Heart Failure certificete 1 Tas 2 No 1 ☐ Yes 2 ☐ No Division of Vitai 25. Was case referred to medical 8 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 at or Attending Physis effector: After this ed in by the funeral d this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital of within 24 hours of To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the 29a. Certifier ner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the ceusa(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dennym nicholar D37606 May 16, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas J. Kohlerman, M.D., 11904-F Darnestown Road, N. Potomac, MD 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State MAY 18 2000 general oaks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day **Physician** 14 2000 Leahy May 5:50AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year Hunder 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Hours Months Deys 1 M 2 X F 579-48-1803 90 October22,1909 Ireland Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ahow nel Hygiene. d other than "natural", or itema 23a or 28a-f ahov event, the Medical Examinar must be notified at Washington, D.C. 187 Yes 2 1 No None None Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 20016 4201 Butterworth P1. #310, N.W. U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Switchboard Private Industry 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Heelth and Mentel Hy Important: if Item 27 is marked otherly any Injury or other traumatic event Bartholomew Leahy Catherine Broderick 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retetionship (Type, Print) Joseph Fritsch/ Friend 806 Bay Drive, Stevensville, Maryland 21666 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 17 1 Buriai 2 □ Cremation 3 □ Removal from State 2000 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Washington, D.C. 21. Signature of Pureral Service Licenses 22. Name end Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash. D.C. 20007 23e. Pint Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one ceuse on each line. Approximate Intervat Between Onset and Death Physician is Respiratory /Medical tmmediate Ceuse (Final disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or es a consequence of) nai uni 9 of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): enovatrue Arthit's Elezabrech Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nuknown Completed by 24e. Was an autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? certificate has 1 Yes 1 ☐ Yes 2 ☐ No Director: After this certific d in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Piace of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Neturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide or after To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner as stated.

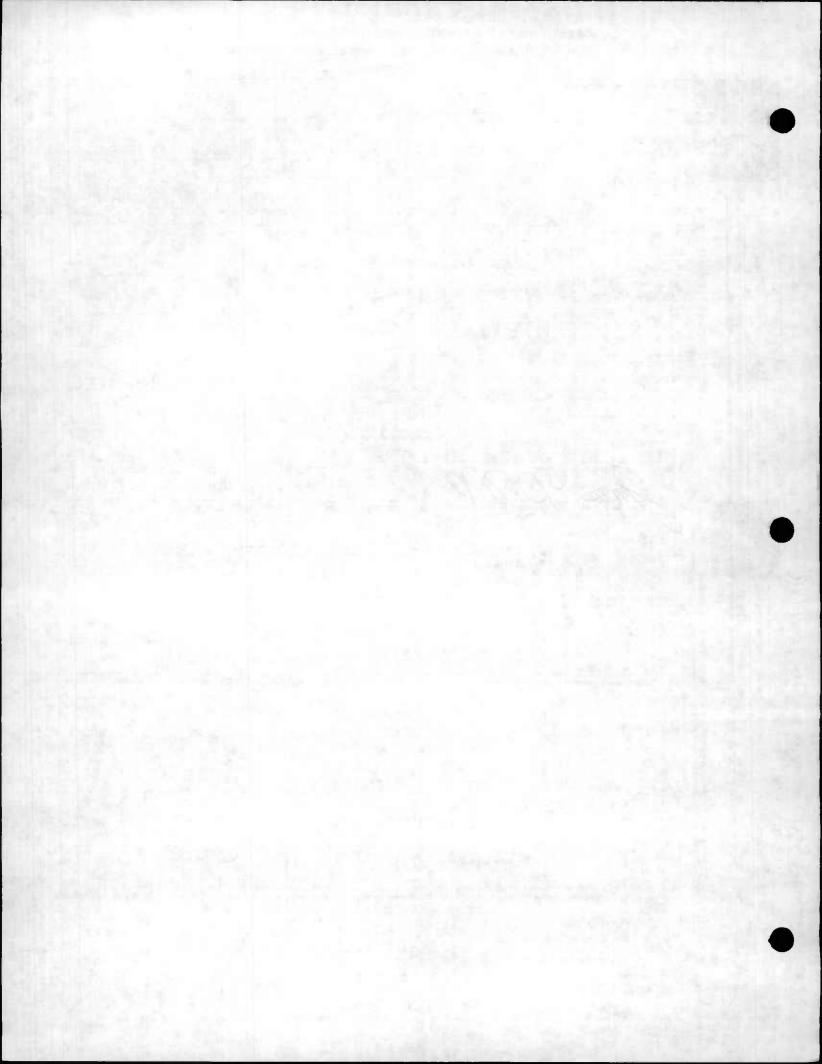
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 020415 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Los pare 0 ESAPANDE AMALINGG

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Year)

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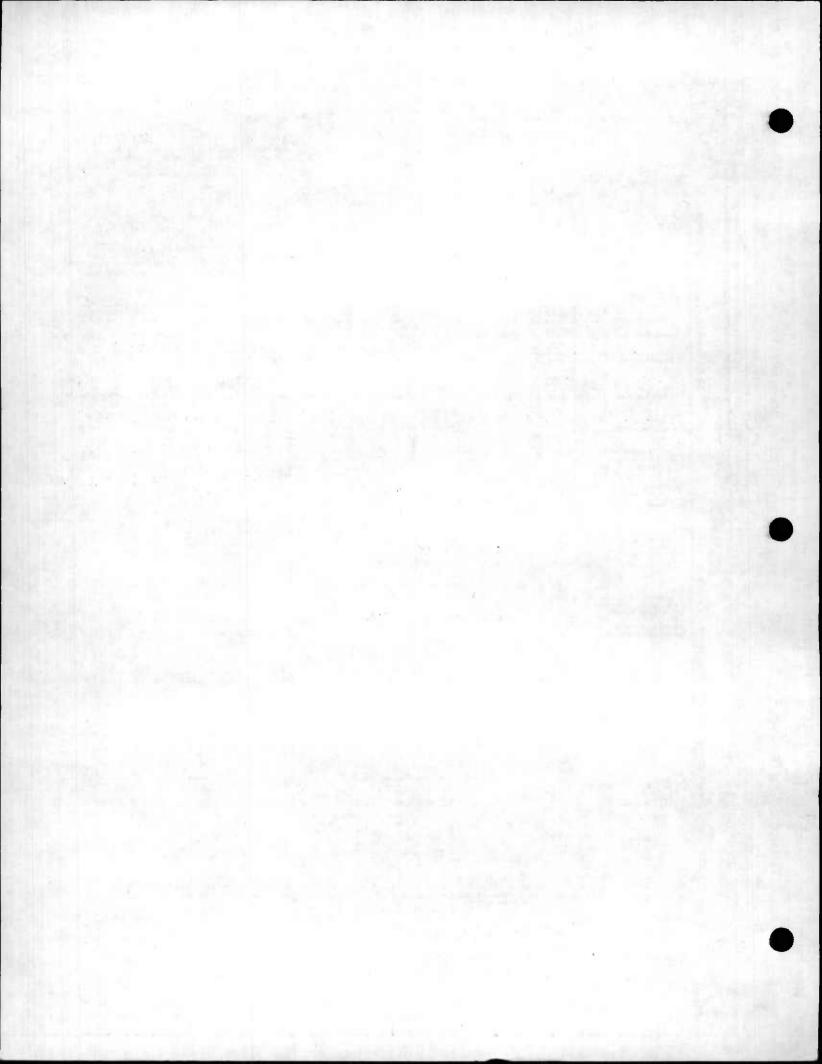
32. Registrar's Signeture



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State of Maryland / Department of Health and Mental Hygiene 0 173

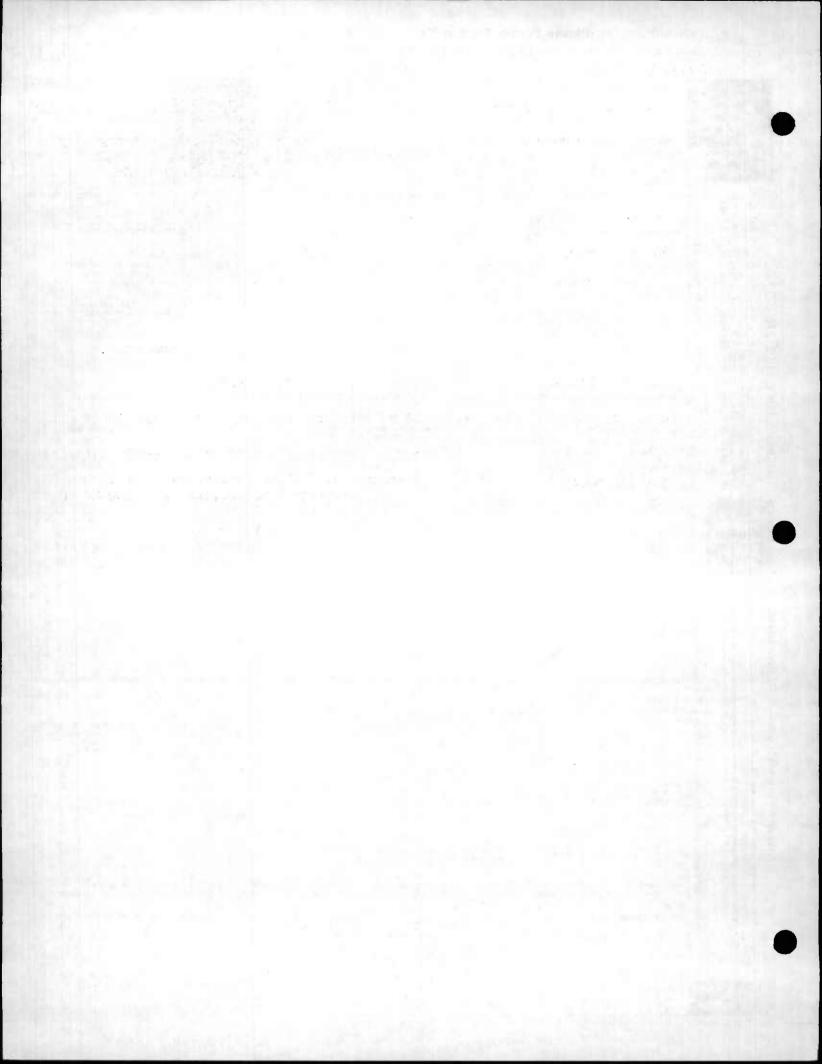
				Certific	cate of	Death		Reg. No.	
	1. Decedent's Nama (First, Middla	Last)		10000			2. Date of D		3. Tima of Dea
Physician		Genevieve	I. Leary				Month May	Day 10, 2000	7:11 pi
/Medical	An Chailin hama /// and institution				1	4b. City, Town, o			
Examiner									
		ban Hospi 6.Sex		takata al Hil	Jnder 1 Year	Beth			ntgomery
Funeral	5. Social Security Number	1 M 2 X F	7. Aga (In yrs. last b		nths Days		n. (Month, D		Birthplace (State or For Country)
Director	132-20-3392		72	113.			Decembe:	r 15, 1927	New York
2 .	Usual Rasidance of Dacedant 10a. State 10b. County		100 City To	wn or Location					10d. Inside City Li
the sale			100. 01.9, 10	WIT OF EDUCATION					
or 28a-f sho be notified at Director	Maryland Mont	gomery			Ro	ckville			1 ☐ Yas 2 🔀
or 28s-f s be notified	10e. Street and Number			10	M. Zip Code			10g. Citizen of V	Vhat Country?
2 4 7		ville Pike	# 918			20852		Unite	d States
fler death in the result in th	11. Marital Status	12. Was Daced	dent Ever in U.S.	13. Was [Hispanic Origin?	Specify Yas or N	o- 14. Rac	e - Amarican Indian,
and P	1 Never Married 2 Marrie	Armed For		If Yas	, specify Cub	an, Mexican, Pue	erto Rican, etc.)	Blac	k, White, etc.
in 72 hours after n "natural", or its dedical Examins oleted by Fu		If Yas, Giva	1	1 D Y	as 2 X No	Specify:		Specify	
2				a. Decedent's	Heuel Occur	nation		16h Kind of Ru	White sinass/Industry
ygiene. ser than "natur r, the Medical.	(Specify only highas)	grada complated)	10	(Give kind	of work done OT use retire	during most of w	orking	100. Kind of Bu	ismass/moustry
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		5+		Transpo	ortati	on Econo			
		ast)				18. Mothar's N	ema (First, Middl	a, Maiden Sumem	e)
h and Mantal F is marked of traumatic even		orge Loes	sch				Jane 1	Black_	
PER	19a. Informant's Name/Reletionsh	p (Type, Print)	19	b. Mailing Ad	dress (Street	and Number or i	Rural Route Num	ber, City or Town,	State, Zip Code)
oath a n 27 is ner trau	Brian M. Leary	Son	51	8 Easts	A POOR	oad Fair	field.	Connection	ut 06432
エニサン	20e. Method of Disposition	3011	20b. Place	of Disposition	(Name of		Data		City or Town, Stata
るここし	1 ☐ Burlal 2 🎇 Cramation		tate camar	ary, cremator	y or other ple	ce)	May 12.		
ment tant:	4 Donation 5 Other (Sp.	ecity)	Montgo	mery Cre			2000		a, Maryland
ad A in	21. Signature of Fudaral Service L	censee		Robe Nan	na and Addre	Pumphrey	Funera	1 Home/	isconsin Ave
88 5 5 5		111	W00225	Beth	esda-C	hevy Cha	se Inc	257557 W	isconsin Ave
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	23a. Part1. Entar that diseasa, or c shock, or heart feilure. List of	nly ona ceusa on aa	ch line.					-,,,	Inlarval Batweel Onset and Deat
hysician /Medical	Immediate Course (Final								
/iviedical Examiner	Immediata Causa (Final disease or condition	. Car	diac Arre	est					Hours
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ding physician end ise as the burial-transit	Sequentially list conditions, if any, leeding to Immadiata causa. Entar Underlying Cause (Disaase or injury that initiated avants								0 **
sicia	Cause (Disaase or injury	c. Bro	nchogenic Dua to (or as a						3 Years
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nding p		d							
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requires that the bearn wen signed by the atte hould be detached for							-		
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							per	formed?	completion of cause of death?
hes by 2 s mpl									
cate he							1	Yas 2 No	1 ☐ Yes 2 ☐ No
this certificate ral director, pag. To Be Co	25. Was casa raferred to medical axaminar?					26. Placa of D	eeth (Check only	ona)	
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octor: After by the fune ification	1 Natural 5 ☐ Pending 2 ☐ Accidant investige		, Dey rear)	Injury M		Yes 2 No			
death ctor: / y the flcat	3 Suicide 6 Could no	ot be 28a, Place o	of Injury - At homa,	farm, street, fa	actory office		28f. Location	(Street and Numb	er or Rural Routa Number,
in the	4 Homicide determin	building	g, atc. (Specify)	,,	actory, omico		City or To	own, State)	
n 24 hours after death. The forms after death. Funeral Director. After the pletely filled in by the funeral edical Certification:									
ca ey	29a. Certifiar 1 X Certifying (Check only 2 Medical E	Physician: To the b xaminer: On the bas							nner as stated. and due to the cause(s)
within 24 hours after of the funeral Direct completely filled in by Medical Certifi		and manna	ar statad.		,,				
within To the comple		1 11	1		29c. Licens	se number		29d. Data signer	d (Month, Day, Year)
22	1 / fred 1	H Hora	de my	2	D	47701			11 2000
10		1 / /			-	47791		May	11, 2000
	30. Name and addrass of person w)(1	00051	
	David A. Holden,			LII Roa	id Koc	kville,	maryland	20851	
State	31. Data filed (Month, Day, Year)		gistrer's Signeture	4	bock				
Registrar	MAY 15	ZUUU	eneral	1. K	your.	2			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 17340

					Ce	rtificat	e of	Death			Reg. No.		
	1. Decedent'a N	ame (First, Middle, L	ast)		-					2. Date of De	eath	Vale	3. Time of Deeth
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xaminer								-			40.0		
	5. Social Sacurit	igton Adve	Sax	_	la as falush da.	If Under	1 Vear	Takon If Under:	a Pa		-41-		gomery
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ctor	522-64 Usual Residence			80	113.					Nov. 1	7,191	9 Col	orado
	10a. State	10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Lim
5				1	,,								1 Vas 2
200	Colorado		der		Loui	svill							44
Directo	10e. Street and I	Number				10f. Zip	Code				10g. Chiz	en of What C	ountry?
To Be Completed by Funeral Director	836 Rex	Street					800)27			U	SA	
Funeral	11. Merital Statu	s	12. Was Dec	edent Evar in U, orces?	S. 13.	Was Deced	dent of F	lispanic Orig	In? (Sp.	ecify Yes or N Ricen, etc.)	0- 1-	 Race - Am Black, Whi 	arican Indian,
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Be	17. Father's Nan	ne (First, Middle, Las	et)					18. Mothe	r's Nam	e (First, Middle			
10 8	Walter	Strand						Mar	**	Brehm			
-		Name/Relationship			19h Maili	na Address	(Street	Mar	-	al Route Numb	er City or	Town State	Zin Code)
	20a. Method of D	Gayton	(Hu	sband)	836 R	ex St	reet	Lo	uis	ville,C	olora	do 80	0027
		2 Cremation 3 (Removal from	0	emetary, cra	matory or o	ther pla	ce)	i	Data	200. L00	ation - City of	Town, State
	4 Donatio	n 5 Other (Spec	ify)	Lou	uisvil	le Ce	mete	ery_	5,	/24/00	Louis	ville,	Colorado
OUC	11111	Funaral Sarvice Lice	ensea					ss of Facility	У				
a	y. 10	is Stile								Funeral			
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Completed											1	/	of death?
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Sa	29a. Certifier (Check only	1☐ Certifying Pi 2☐ Medical Exa											
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	V.L.	dress of person who	100 111) /////	b- CL	111/2	D:	Lo PI	mp	2U2 X	204	illo	MD 2085
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State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** SYLVIA B. LIGHTMAN MAY 11 2000 11:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 608 LAMBERTON DRIVE SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. 8. Date of Birth
(Month Day Year)
FEBRUARY 16, 9. Birthplace (State or Foreign 914 PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2♥F 86 Yrs. Director 222-03-8277 Usual Residenca of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD MONTGOMERY ty∑ Yes 2 No SILVER SPRING Director 28a-f must be notifi 10g Citizen of What Country? 10e Street and Number 10f. Zin Code tems 23s or 608 LAMBERTON DRIVE 20902 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status Black White etc. hours after 1 Never Married 2 Married 8 21215-0020 WHITE 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired)
ANALYST 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry
UNITED STATES 22 filled within Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 4+ GOVERNMENT 17. Father's Name (First, Middla, Last) JACOB BAYLIN Maryland 18. Mother's Name (First, Middle, Maiden Surnama)
SADIE GELFOND Pages 1 and 2 should be fit thrent of Health and Mental H tant: If Nem 27 is merked off Be 2 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any injury or other tras. JOSEPH M. LIGHTMAN (HUSBAND) 608 LAMBERTON DRIVE SILVER SPRING MD 20902 altimore, 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition

1 PBurial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 5/14/00 21. Signature of Funel ervice Licensee DANZANSKY GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE MD 20852 23a. Part1. Enter the diseete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 that the death certificate be Physician/Medicai the Due to (or as a consequence of): 88 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of causa of death? The law page 2 certificate has 1 ☐ Yes 200 No 1 ☐ Yes 22 No of Vital Be 25. Was casa referred to medical 26. Place of Death (Check only one) 1 Yas 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Attending Natural 5 Pending investigation death. Director: A 1 Yas 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide ò To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 Grano Hole

State Registrar 10400

Cornections Ar

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

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MAY 15 2000

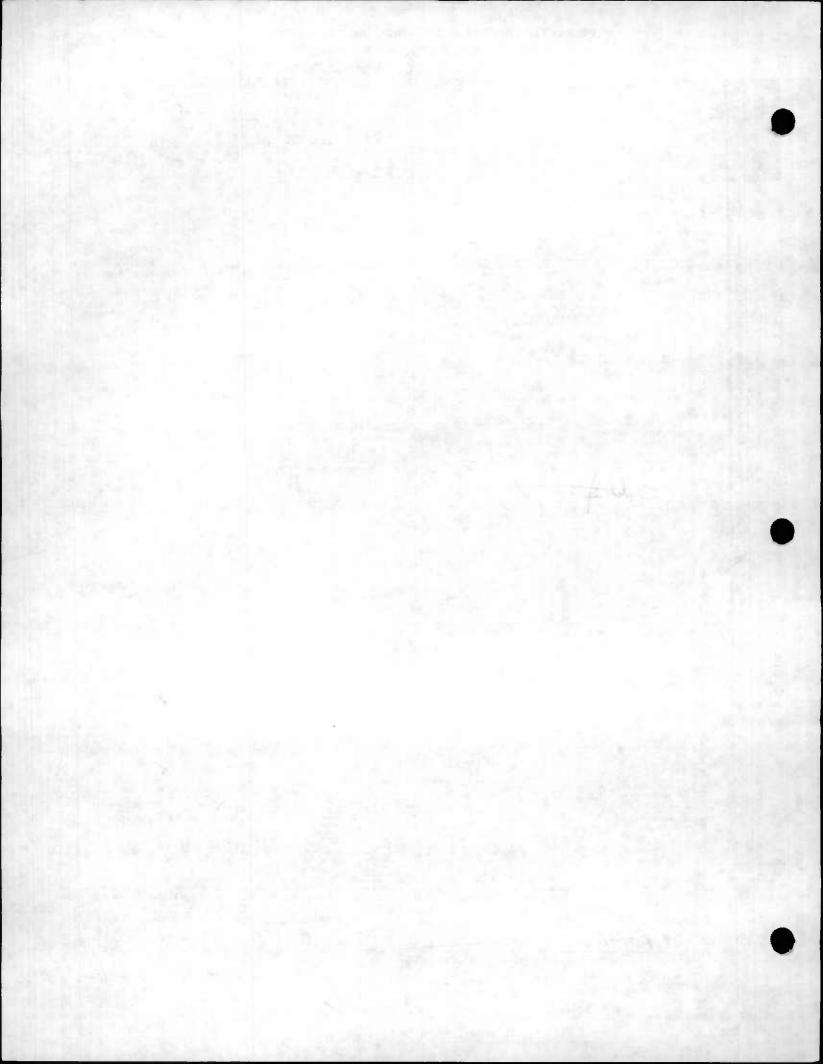
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31. Date fited (Month, Day, Year)

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32. Registrar's Signatura

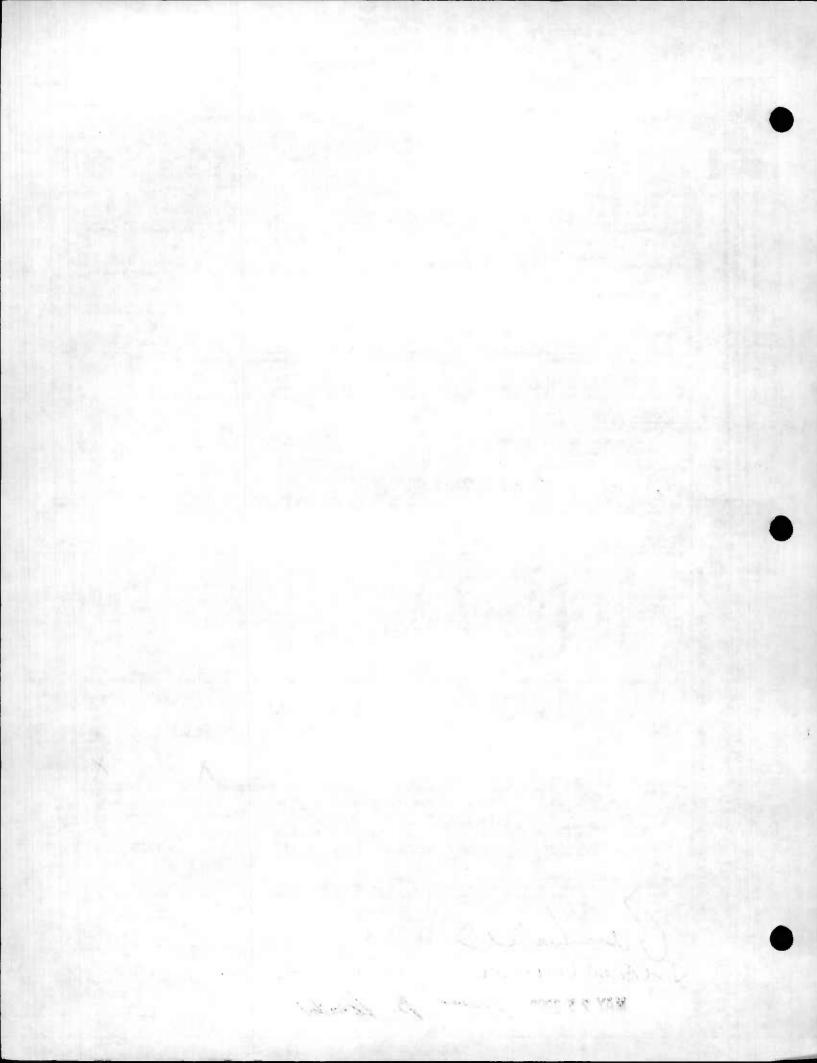


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Lewis	McGowa AMEND	an, IV ITEMS:	#1,	23	PART	I,	Stat 27,	e of Ma 28A-F	ryland PER	/ Department of Health and MEC G784 6-6-60 WR Certificate of Death	Mental Hygiene Reg. No.	00	17342
	Physi		cedent's N	lame (First, Middl	le, Las	t)				2. Date of Death Month Dey	Year	3. Time of Deat

	1. Deced	dent's Name (First, Mi	iddle, Last)						2. Date of Month	Death Dey		Year	3. Time o	Death
cian lical		LOUIS M	(cgo)	JAN.T	V					May	18		000	09:22	P.M
ner	4a Facili	ity Name (If not institu	ition, give	street and nu	umber)				4b. City, Town,	or Location of D	eath 4c. C	ounty o	of Death		
		Anne A	Arund	del Med	dical	Cente				polis		nne	Arun	del	
	212-	Security Number		x MM 2□F	7. Age (In 2.8	yrs. last bin	thday) If Under Months	or 1 Year Days	Hours M	rs. 8. Dete of (Month,	Birth Day, Year) 2 19	72	9. Birthpi Count MAR	ace (Stete try) YLAN	or Foreign
	10a. Stat	esidence of Decedent le 10b. Cour			100	. City, Tow	n or Location				-	_	10	Od. Inside C	ity Limits
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		15. Deced	dent's Edu	cation		16a.	Decedent's Usi	uel Occup	nation during most of a	endrina	16b. Kind	of Bus	siness/Inc	lustry	
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	LC	OUIS McGC	DWAN	III						'A BROV					
		ormant's Name/Relation			urn)				and Number or						1239
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		Donation 5 ☐ Other	* * **		A	NNAP			GARDEN	IS 5/24	4700 A	NNA	APOL	IS,	MD.
	21. Sign	ature of Funeral Servi		-	An .				ss of Facility	MC MOI	עם גוזיים		7.		
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State Registrar

32. Registrar's Signeture B. Spark



State of Maryland / Department of Health and Mental Hygiene 00 17343

			Ce	rtificate o	f Death		R	leg. No.	, ,	10-70	
veision	1. Decedent's Name (First, Middle, L						Date of Dea	th	Year	3. Time of Deeth	
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miner	4a Fecility Name (If not institution, g Southern Marylan	nd Hospital			Clint			Princ	e Ge	eorges	
or	5. Social Security Number 134-03-5790 Usual Residence of Decedent	WILL OF C	yrs. last birthday	Months Day		Min. 8.	Date of Birth (Month, Day Dr. 1	Year) , 1910	9. Birthi Fin I	placa (Stete or Foreigr ntry) .and	,
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unt be notified at rel Director	10e. Street and Number 5363 Deale Churc	chton Road		10f. Zip Code 2073				USA	What Cou	ntry?	
by Funeral	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yas 2 No If Yes, Give Year or Datas:	in U,S. 13.	Wes Decedent of If Yes, specify C			Yes or No- an, etc.)		e-Americk, White, White		
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To Be C	17. Fether's Name (First, Middle, Las Raatali Henry			1.1		er's Name (Fi	~	Maiden Surmem Dininen	10)		
-	19a. Informant's Name/Relationship Toini Belluomin:			ing Address (Stre		er or Rural Ro	oute Numbe	r, City or Town,	State, Zip	Code)	
	20a. Method of Disposition 1	□Removel from State M	Ob. Place of Disp cometary, cre letropoli	osition (Name of emetory or other p itan Cre	matory	5/19	9/2000	20c. Location - Alexar			
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an al	23a. Part . Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	nplications that caused the yone cause on each line.						rest,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximete Interval Between Onset and Deeth LWEEK	
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edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. CHRONI	to (or as e conse to (or es e conse	TRUCTE	VE A.	IRW1A	y D	ISEASE		MURETHALYEAR	~
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0	1 ☐ Yes 2 No	Hospital: 1 Unpatient	2 ER/Outpatie	INT 3LI DOA		ursing Home	5 Resid	ence 6 Oth	er (Speci	(y)	
Certification:	27. Manner of Death Control Cont		ar) 28b. Tima o	V	njury at Vork? ☐ Yes 2☐		. Describe h	ow injury occur	red		
Medical Certification: To Be	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injury building, etc. (S)	At home, farm, st pecify)	treet, fectory, offic	De .	28f.	Location (5 City or Tow	itreet and Numb n, State)	er or Run	rel Route Number,	
edical	29a. Certifier 1 Certifying P 2 Medical Exa	hysician: To the best of my miner: On the basis of exa and manner stated.	r knowledge, deal mination end/or in	th occurred at the nvestigation, in m	tima, data ar y opinion, dea	nd place, and ath occurred a	due to tha c it tha time, c	cause(s) and ma data end place,	annar as : and dua !	stated. to the cause(s)	
×	29b. Signature and title of certifier	c Fura	mp		ense number	53		29d. Date signe 5 -		Dey, Year)	
	30. Name and eddress of person who					C. SU ALE		P 20	275	7	
State gistrar	31. Date filed (Month, Day, Year) MAY 2 2	32. Registrer's S		, ,	alle	7 100 500			•	+	
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 15, 2000 5:55 P.M. Cora Lee Malusheski /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1□ M 20 F Hours Days Months 216-22-1414 86 June 22, 1913 North Carolina Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylan 1 ☐ Yes 2 No 28a-fa Prince George's Maryland Suitland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be n 6208 Auth Road 20746 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) or Herris 11. Marital Status filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 8th College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Jadie Hildreth Rosa (unknown) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) William L. Malusheski/ Son 6208 Auth Road Suitland, Maryland 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition WABurial 2 Cremetion 3 Removel from State 20c. Location - City or Town, State Date Cedar Hill Cemetery 5-18-00 Suitland, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** nour /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner physician end the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760 The law requires that the death certificate be Due to (or as a consequence of): 89 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Denknown of Vital Records. þ page 2 should b 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was cese referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4☐ Nursing Home 5☐ Residence 8 ☐ Other (Specify) 1 Yes 2 160 1 Dumpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after deeth. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of p

31. Date filed (Month, D

DHMH 16 Rsv 6/95

use of death (Item 23a) (Type, Print)

32. Degistrar's Signature

State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Date of Death 1629 Reese T. Mabe May 11 2000 4a Facility Name (II not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Harford Memorial Hospital Havre de Grace Months Days Hours Min. April 30, 1921 North Carolina 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) Months 1₩ M 2□ F 226-12-5886 Usual Residence of Decedent 10s State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 628 Pinehurst Street 21001 12. Was Decedent Ever in U,S.
Armed Forces?
1 20 Yes 2 No
If Yas, Give
Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritai Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elemantary/Secondary (0-12) Ewuipment repairman Quarry 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry W. Mabe (Son) Aberdeen, Maryland 21001 628 Pinehurst Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Baker Cemetery 5/15/00 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Abordeen. Maryland 21001-3399 21. Signature of Europral Service Licensee 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause or each line. Approximate Interval Batween Onset and Deeth Immediate Cause (Final disease or condition resulting in death) 3b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician: The law requires that the death certificate be axecuted

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Completed

Medical Certification: To

P.O. Box 68760.

Records.

Division of Vital

Rees

Physician

/Medical

Examiner

Director

Funeral

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MD

Funeral

Director

6 238

'natural', or

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oths any Injury or other traumatic event

21215-0020

Baltlmore, Maryland

2000

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Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate Cat Ca tha res Par

25. Was casa referred to medical

30. Name and addoes of

use (Disease or injury it initiated events ulting In death) Last	c Due to (or as a consequence of):	
t II. Other algnificant conditi	ons contributing to death but not resulting in the underlying cause given in Part I.	23

24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

examiner?	No	Hospitat: Inpatient 2	☐ ER/Outpatient 3	DOA	Other: 4	☐ Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 2 Accident	5 Pending investigation		28b. Tima of tnjury	1	Injury at Work? 1 Yes	2 No	28d. Dascribe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		homa, farm, street, f cify)	lactory, of	fice		281. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Cartifier	1 Certifying Ph	veicles. To the best of my k	nowledge death occ	urred at th	he time d	ate and plac	and due to the cause/s) and mannar as stated

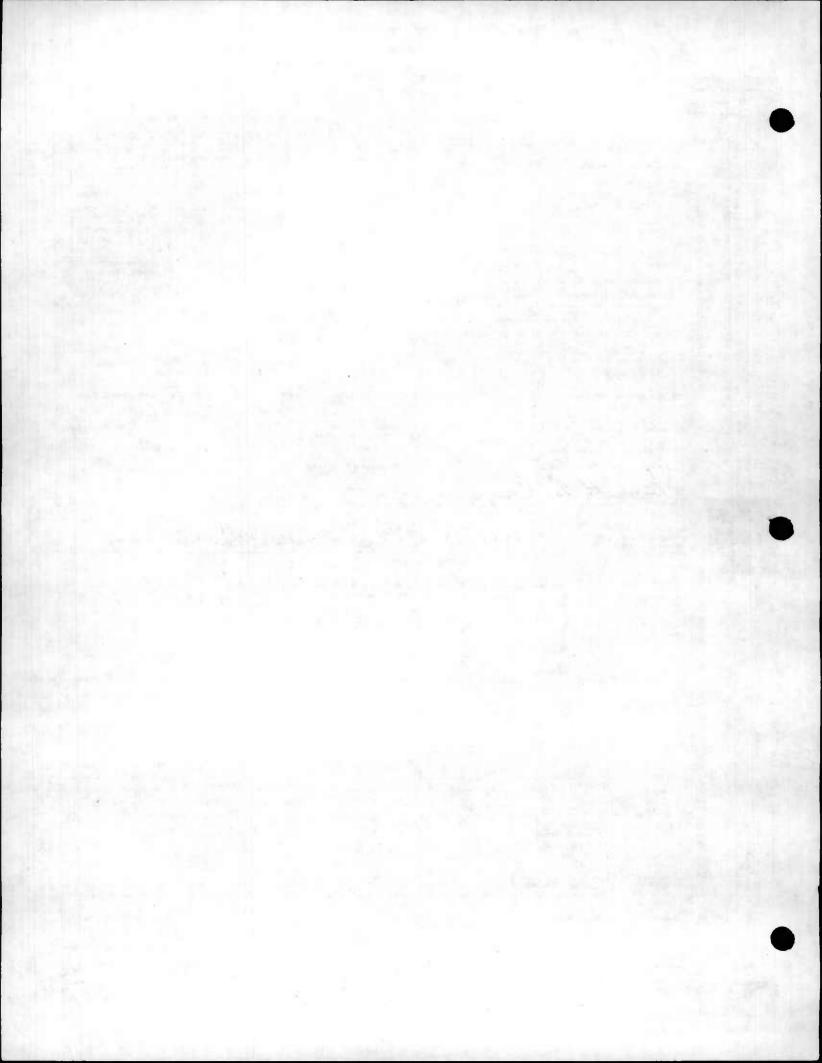
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dale signed (Month, Day, Year) 29b. Signature and title of certifier

after death filled in by

24 hours a Hospital

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State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 2000 03 9:05pm May Lela Pitcock Mentzer /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give streat end number) 4c. County of Deeth Examiner 553 Giles Street Havre de Grace Harford 9. Birthplece (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/04/1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2X F Vre 76 Director 219-18-0477 Usual Residence of Decedent with the Marylend 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f ehow any injury or other treumatic event, the Medical Examiner must be not refer at 1 XYes 2 □ No Director Havre de Grace MD Harford 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 553 Giles Street 21078 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritel Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 3altimore, Maryland 21215-0020 1 Yes 20 No Specify: þ White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Home Homemaker 12th 18. Mother's Neme (First, Middle, Melden Surneme) 17. Fether's Name (First, Middle, Last) Be P Lela B. Ferguson Elaie M. Pitcock 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 2508 Lincrest Rd., Joppa, MD 21085 Barry Wentzer- Son 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Mountain Christian Cem. 5/8/00 Joppa, MD 22. Neme end Address of Fecility 21. Signeture of Funerel Service Licenses Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, shock, or heart feilure. List only one ceuse on each line. MD 21078 Approximete Intervel Between Onset and Deeth **Physician** ARSIAC HERYTHMIA Immediate Ceuse (Finel disease or condition resulting in deeth) /Médical DEL Examiner Examiner GRIOSCLEROTIC ettending physician end for use as the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) USTASE Division of Vital Records, P.O. Box 68760, Physician/Medical thet initiated events resulting in deeth) Lest Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. signed by the 1 Yes 2 No 3 Probably 4 Unknown by tate hes been signated by page 2 should b 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 2 NO 1 Yes 1 ☐ Yes 2 ☐ No certificate Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3 DOA 1 Inpatient 2 ER/Outpetient After this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No Hospital or Attending to the Hours of the death
 Funeral Director: A 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only To the Within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature & OCME 00 1 30. Name and 24 of perion who completed cause of deeth (Item 23e) (Type, Print)

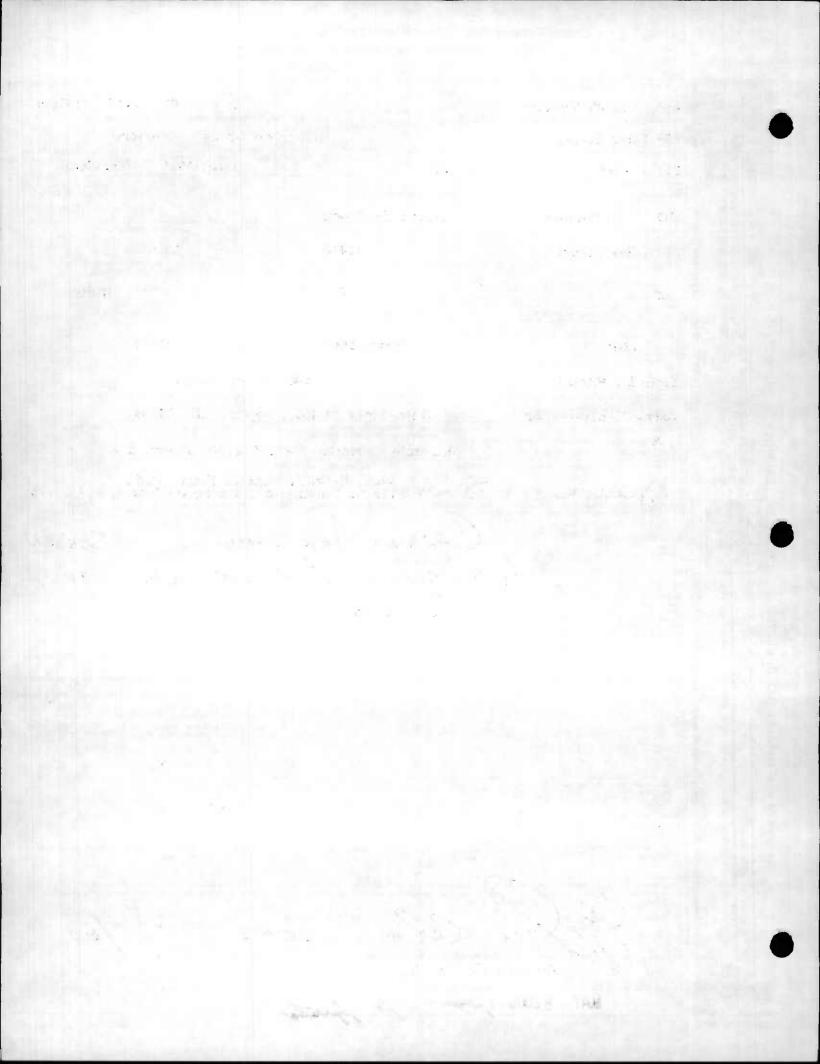
State Registrar

31. Dete filed (Month, Dev. Year) 8 2000

32. Registrar's Signeture

MIALEK, M.D

Spark



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Tima of Death Deyth 2000 1:30 Am Month 14 May Robert Seibert Martin Jr. 4b. City, Town, or Location of Death 4e Facility Nama (If not institution, give street and number) 4c. County of Deeth General Chrroll County Waszminster nosvital | Months | Days | Hours | Min. | Mar 6 1926 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 10 M 20 F 74 220-18-1350 MD **Usual Rasidence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2r ☐ No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 37 Goni Terrace 21157 USA 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1944 If Yes, Give Year or Detes: 1946 13. Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2€ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Board of Elementary/Secondary (0-12) College (1-4or 5+) Education Supervisor of Science 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Robert Seibert Martin Sr Dorothy Chaney 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Goni Terrace Westminster, MD 21157 Gloria Martin/wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Data 20c. Location - City or Town, Stete 1 ☐ Burial 2 【Cremation 3 ☐ Removel from Stete Carroll Cremation 5/15 Hampstead. MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service License 22. Nama and Addrass of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock or heart feiture. List only one cause on each line. Approximate Intervel Between Onsat and Death Immediete Causa (Final disease or condition resulting in death) eymoni Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes en eutopsy parlomed? Corona completion of cause of death? di seage 2 No 1 Yes 2 No 25. Was case referred to medical axaminar? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Examiner Division of Vital or Attending Physician: this After n 24 hours after death.

Funerel Director: Afti Hospital To the Hosp within 24 hor To the Fune completely fi

Physician/Medical Completed by Be Certification: To

Examiner filled in by

Physician

/Medical

Examiner

Director

Funeral

Director

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Maryland 21215-0020

fligd within

permi. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any Injury or other traumetic eventi.

Physician

/Medical

27. Manner of Death 1 Seletural 2 Accident 3 Suicide

(Check only one)

29a. Certifier

6 Could not be 4 Homicide

28a. Date of Injury (Month, Dey Year) 5 Pending investigation

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) TS-Certifying Physician: To the bast of my knowledge, deeth occurred at the tima, data and place, and dua to the ceusa(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and menner stated.

Wastminster,

29b. Signature and title of certifie

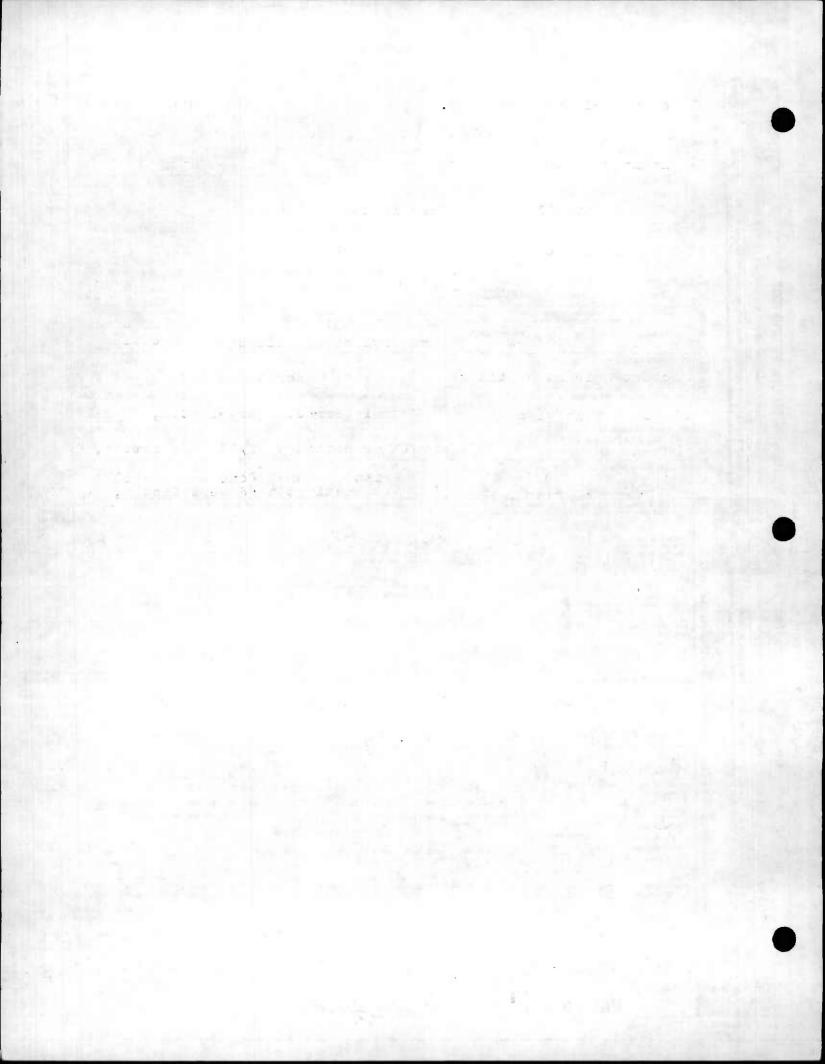
29c. License numbar 30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

29d. Dete signed (Month, Day, Year) 2000

BOAIT 200

31. Date filed (Month, Day, Year) MAY 15 2000 32. Regisfrar's Signature

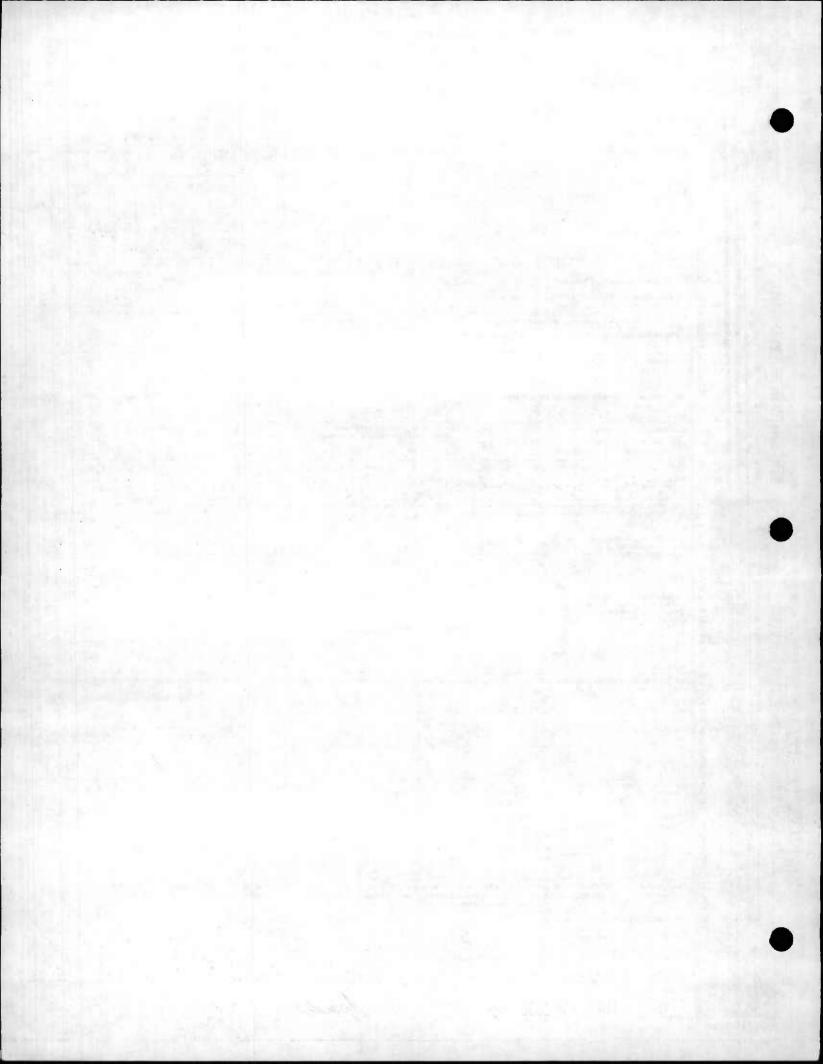
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 17349

			(Certificate	of Death		Reg. No.		
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Physician	Lester Conrad M	lann. Sr.				Month	12 2	2000	20:30
/Medical	4a Facility Name (If not institution, gi			-	4b. City, Tow	n, or Location of Dea			A
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Funeral . Director	216-07-3820	IN POF	39 Y	Months F	lays Hours	Hrs. 8. Dete of E	10, 1910	Cou	ntry)
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255	E. May Mann/Wife		360	07 Gamber	Road Fi	nksburg,	MD 21048	3	
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Dapa Many I	101. 11.7					Jeffrey N.			
	Jan San	now		6028 Sykes	sville Road	l Eldersburg	, Maryland	1 218/4	+
ires that the death certificate be associated signed by the attending physician end do detached for use as the buriel-transit dby Physician Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	C	Due to (or as a co		Infa	rction			11 minute 8 days
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Attanding Physician: r death. setor: Attar this certific by the funeral director, ification: To Be	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injur (Month, Day	Year) 28b. Tir		Injury at Work?		how injury occur	rred	
or Attending Physics of Attending Physics Director: Attential in by the funeral entification:	2 Accident investigation			М	1 ☐ Yes 2 ☐ N	0			
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To the Hospital or Attanding P within 24 hours elter death. To the Funeral Director: After the completaly filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of and manner state	examination and/	death occurred et to investigation, in	he time, date and my opinion, deeth	place, and due to the occurred at the time	e cause(s) and m e, date and plece,	enner as s and due to	stated. the cause(s)
within 2 within 2 To the comple	29b. Signature and title of certifier			29c. L	icense number		29d. Date aigne	d (Month,	Day, Year)
F > F 0	Xisa Kin	n. 111	D	1	57417	0	May	17	2000
	5) /1/. 1		L	5 441	7	1-1-14	12	2000
	30. Name and address of person who	completed cause of de	ath (Item 23a) (T	ype, Print) L1	SA KIM	, M.D 0	r carro	11 0	2000 ounty and 2115
		at 200 1) emorta	HVEN	ine, h	vestmins	ter, M	ary/	and 2115
State	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	6 1					
Registrar	MAY 1.5	2000	neva	D An	m V-1				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** JEAN MILLER FRANCES 5 7 200 0 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Carroll County General Hospital Westminster Carrol1 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplaca (State or Foreign Country) **Funeral** Days 1□ M 200 Yrs. 213-28-8939 69 Director May 19, 1930 Maryland **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland | Carroll Mount Airy 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23s or adical Examinar must be 5154 Perry Rd. 21771 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Stalus 72 hours after 1 ☐ Yes 2 ☒No If Yes, Give Year or Detes: 1 Never Married 2 ⊠ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pamili. Pages 1 and 2 should be lited within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "s any Injury or other traumatic swent, the Med Elementary/Secondary (0-12) College (1-4or 5+) 12 General Employee Bendix Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Edgar A. Tyson Marie Buettner 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joseph L. Miller - Husband 5154 Perry Rd. Mt. Airy, MD 21771 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 ☐ Burial 2 DCremation 3 ☐ Removet Irom Stete Carroll Cremation 5/11/00 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Directors, PA 21. Signature of Funeral Service Moonse 1212 West Old Liberty Rd. Winfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 21784 Physician Immediate Cause (Final disease or condition resulting in death) /Medical a. CEREBROUASCULAR ACCIDENT

Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificete be assocuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? THROMBOCYTOPENIC PURPURA 1 Yes 2 No 3 Probably 4 Unknown Completed by Division of Vital Records. 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? PULMONARY FIBROSIS 1 ☐ Yes > No 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ↑Sinpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Netural 5 Pending To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After completely filled in by the fundamental parts. 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

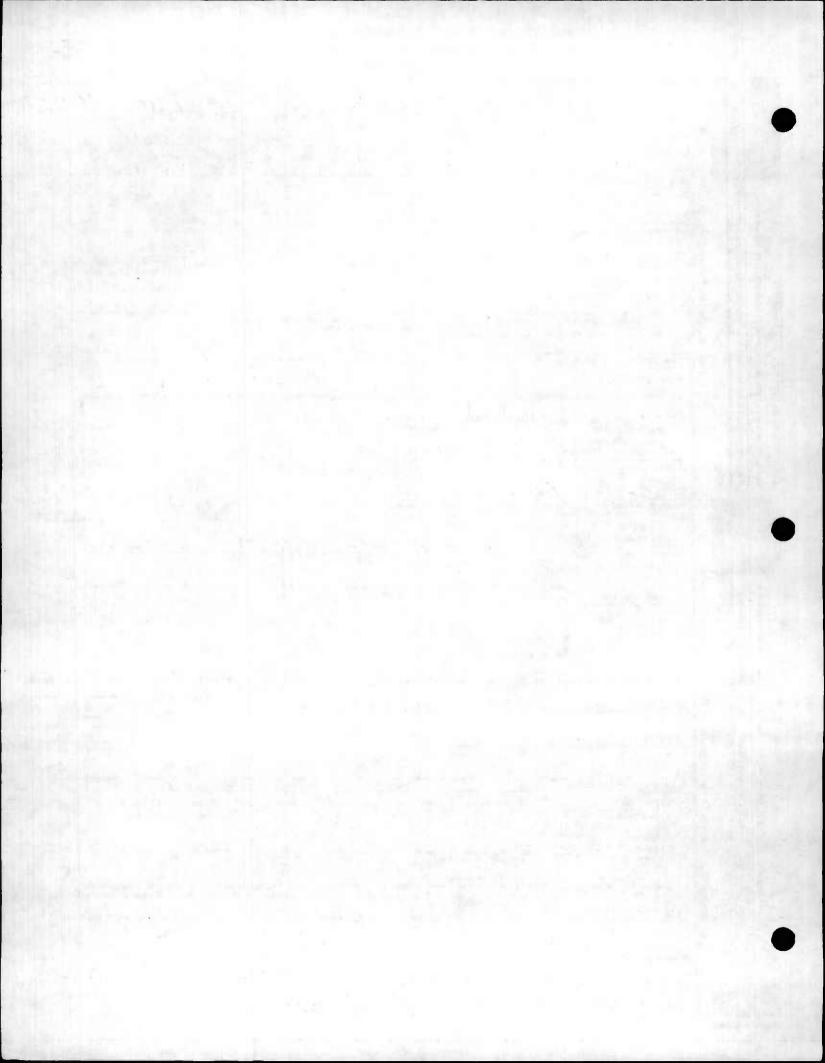
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dale signed (Month, Day, Year) D 25057 100 411 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chogs Ro WNIGS MILLS B 9 Y S 32. Registrar's Signeture 21117 31. Date liled (Month, Day, Year)

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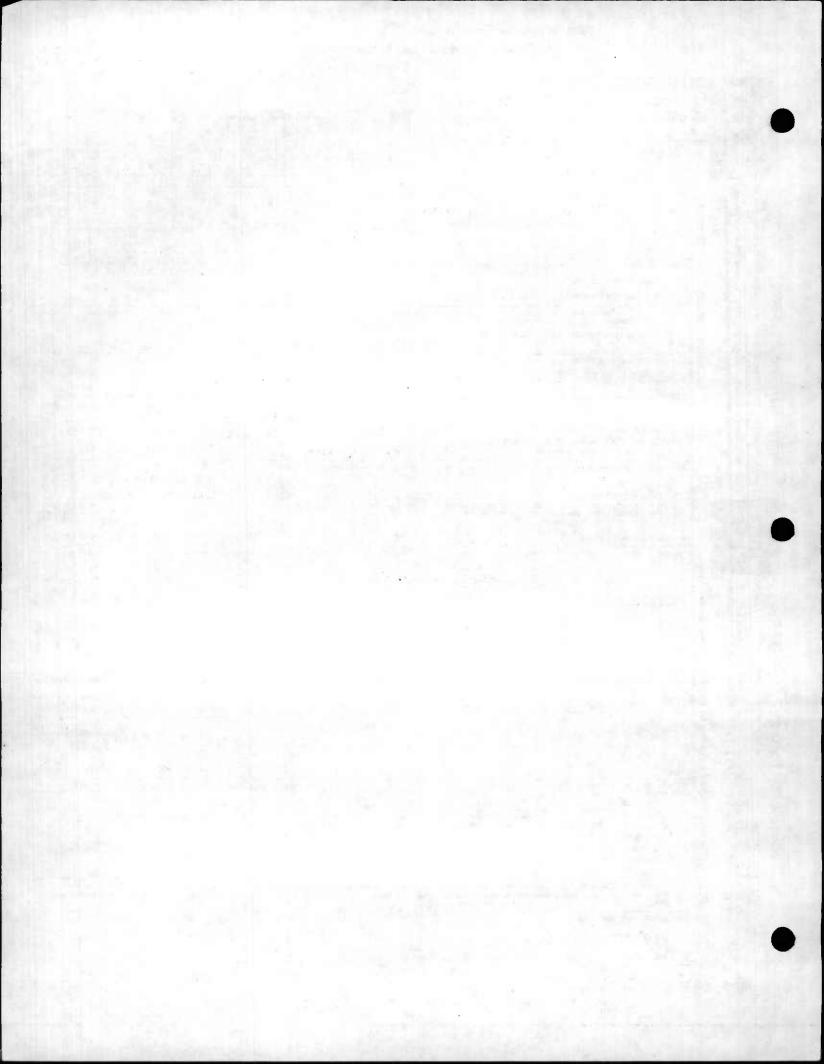
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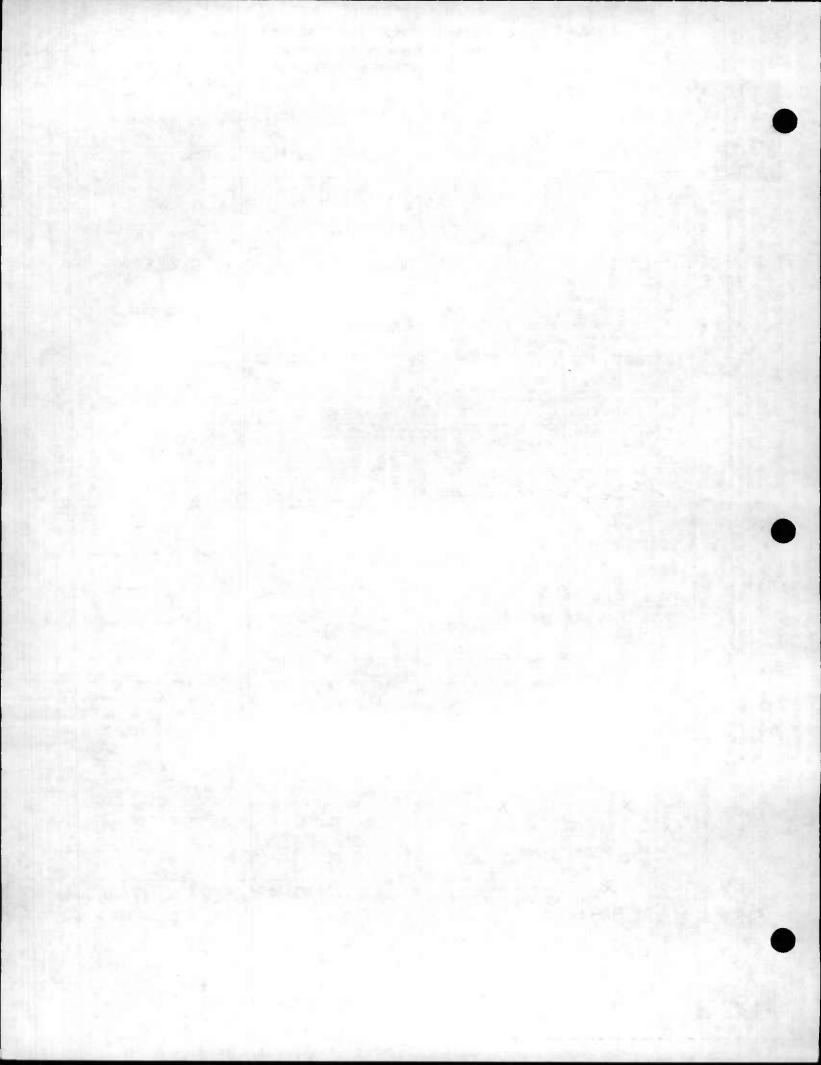


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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Catherine MOL Magistretti 9:10 AM 11,2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Mantgomery Genera
5. Social Security Number 6. Sex Montgomery 9. Birthplace If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 552-34-9599 1□M 20 F 87 Yrs December 27, 1912 Director Virginia Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any loiury or other treumstic event, the Medical Evanties must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery 1 ☐ Yes 2 No Silver Spring 10% Zip Code Director 10g. Citizen of What Country? 10e. Street and Number Road 3aa7 Bcl Pre 20906 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 00 No If Yes, Give 7 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 20 No altimore, Maryland 21215-0020 Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of State 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3300 O Street NW Washington I Guyman Martin/Legal Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Durial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Anatomic Gift Foundation 5115100 Laurel MD 22. Name end Address of Facility
Anatomic Gift Foundation 21. Signature-of Funeral Service Licenses 13948 Baltimore Avenue Laurel Mb 20707 complications that glused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Between Onset and Death 23e. Part1. Enter the diseese shock, or heart fellure. List Physician /Medical Immediate Cause (Final Sepsis week diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Iriwan attending physician end for use as the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 06 hronic Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy s certificete hes t director, page 2 s 1 ☐ Yes 2 No 1 Tyes 2PO No. After this certifice funeral director, or Attending Physician: 25. Was cese referred to medical examiner? Be 28. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined a 24 hours after der Ne Funeral Director bietely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatuse and title of certifier MD 2000 Rockindo

DHMH 16 Rev 6/95

State

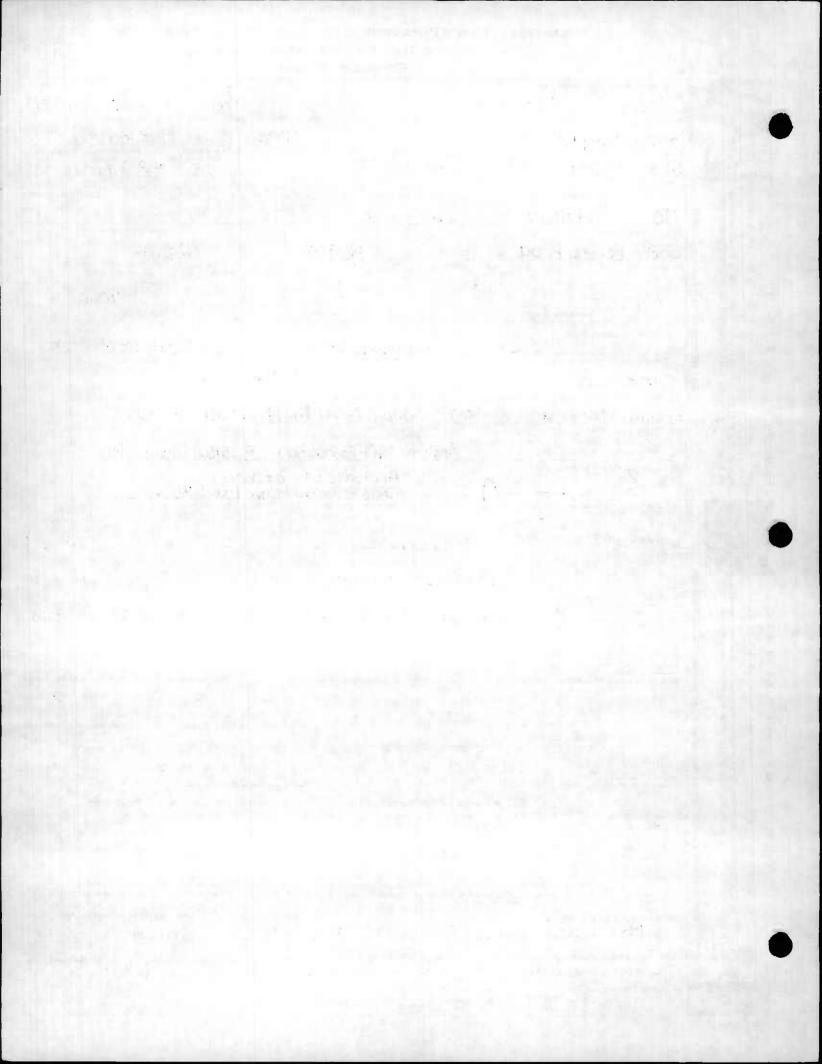
Registrar

31. Date filed (Month, Day, Year)

15

2000

32. Degistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 354 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Bobbie W. Malone AKA Bobby W. Malone May 12, 2000 3:30 PM 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 107 Mannakee Street Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Country) Virginia Months Hours 12 M 20 F 212-34-7434 Yrs. 64 April 16, 1936 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 N Yas 2 □ No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Mannakee Street 20850 United States 14. Raca - Amarican Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanto Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ⊠ Yas 2 □ No If Yes, Give Year or Datas: 1954–1958 1 Naver Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City of Rockville Assistant Superintendent 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel W. Malone Mimmie Neal 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Malone/Son 13510 Ansel Terrace, Germantown, Maryland 20874 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 17 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 2000 Rockville, Maryland Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) ROBERT A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service/Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Myocardial Infarction 1 hour Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco was contributs to the cause of death?

Physician /Medical Examiner

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physician

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The law requires that the death certificate be executed

Attending Physician:

Hospital

Box 68760

of Vital Records, P.O.

Division

Physician

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Completed

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of Hygane. other then "natural", or llems 23s or 23s-f show ovent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Mygiene. Department of Health and Mental Mygiene. Important: If Item 27 is releted other than "natural, or the may injury or other trastratic event, the Medical Examina

Baltimore, Maryland 21215-0020

Examiner

Physician/Medical þ Completed Be Certification: To ours after deab.

I Director: Ah.

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burial-tran the 980 Po signed by been si funeral

To the Hospital within 24 hours a To the Funeral Completely filled 10+1

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or trijury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 Yas 2 No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending Invastigation 1 XNatural 1 TYes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar edicai (Check only one)

30. Name and address of person who completed causa of death (Itam 23a) (Type, Print)

15225 Shady Grove Road #102, Rockville, Maryland 20850 Jonathan S. Plotsky, M.D. 31. Date filed (Month, Day, Year)

State Registrar

2000 MAY 17

29b. Signatura and title of cartifiar

32. Registrar's Signatura Perend

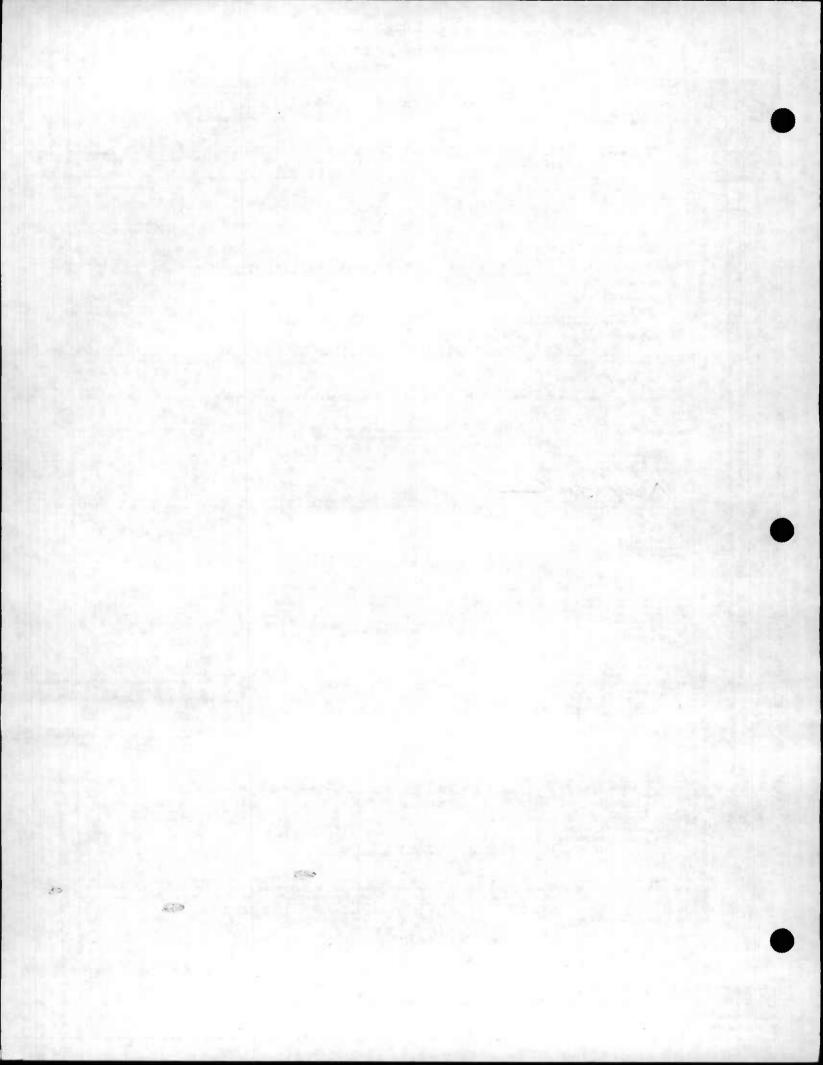
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29c. License number

D38589

29d. Date signed (Month, Day, Year)

May 15, 2000

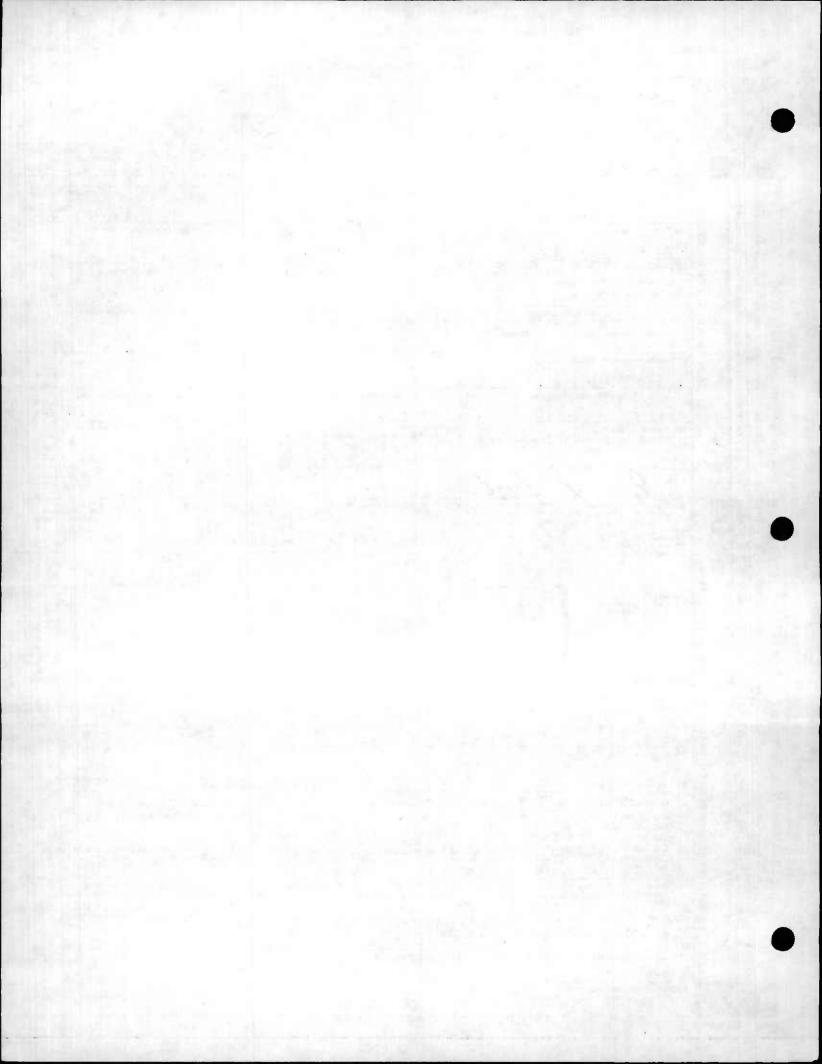


State of Maryland / Department of Health and Mental Hygiene 7355 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Dev MARSHAU Month **Physician** ROBERT 1734 MAY 2000 M /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITON BOTHESOA ME MEGANERY 7. Aga (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax Birthplace (Stata or Foreign Country) **Funeral** 10 M 2□ F Yrs. Director 578-42-9359 66 Nov. 22, 1933 Washington, D.C. Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 9728 West Bexhill Drive Funeral 20895 USA 12. Was Decedent Ever in U,S Armed Forces? TJKN Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, etc. UKN 72 hours after 1 ☐ Yas 2 ☐ No If Yes, Giva Year or Dates: 1 Nevar Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: á 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry ontal Hygione.

ed other than "n event, the Med Elemantary/Secondary (0-12) College (1-4or 5+) Analyst Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is merked other any injury or other traumatic event, pdice. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be P Joseph W. Marshall Alma F. Essex 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 9728 West Bexhill Drive Kensington, Maryland 20895
lace of Disposition (Name of Date 20c. Location - City or Town, State Terrill A. Marshall (wife) 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition Date 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 5/15/00 Suitland, Maryland 22. Name and Address of Fecility
Francis J. Collins Funeral Home, Inc. 21. Signetura of Funeral Service Licensee 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** ARTERIOSCUEROTIC CARDIOURSCULAR DIKORYE Immediata Ceuse (Final disease or condition rasulting in daath) /Medical Examiner Due to (or as a consequence of): Examiner sician and burial-transit Sequentially list conditions, if any, leeding to immediate cause. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in death) Last Due to (or as a consequence of) physician s the bunal Box 68760, Physician/Medical Due to (or as a consequence of): 88 P.O. 1 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should be det Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? page 2 1 Yes 2 No 1 Yas 2 No Division of Vitai 24 hours after death.

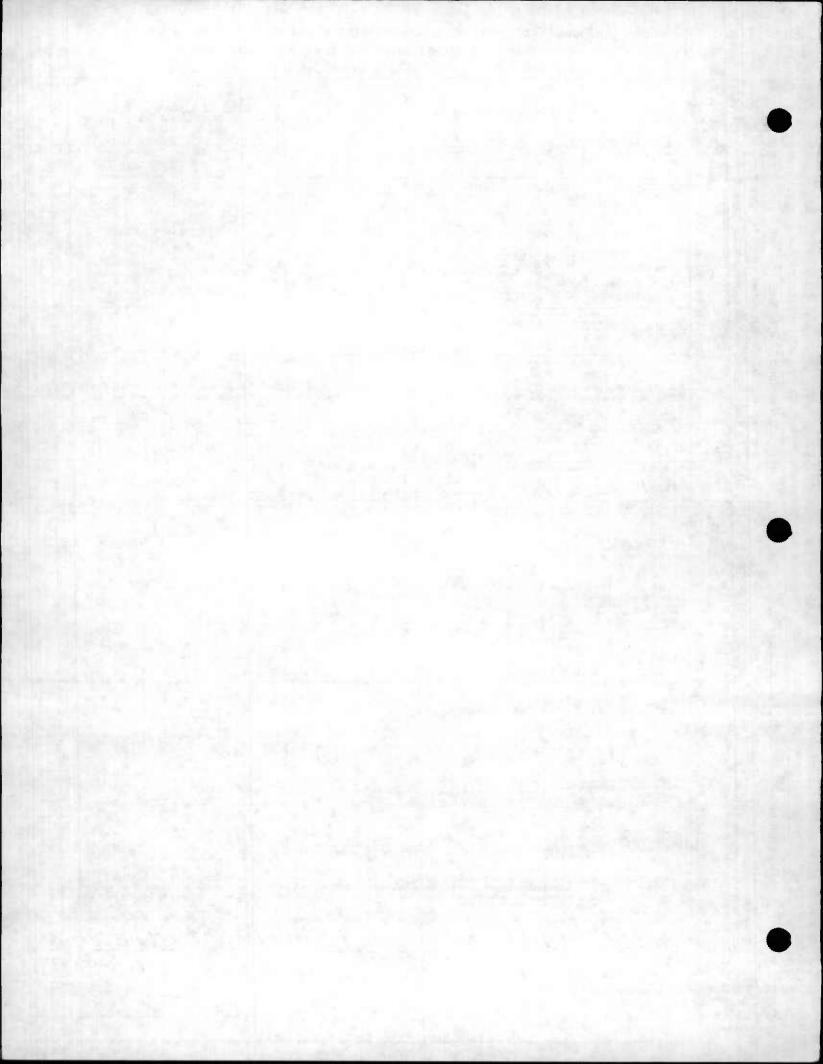
Funeral Director: After this certificate filled in by the funeral director, or Attending Physician: 25. Was casa rafarred to medical Be 26. Place of Death (Check only ona) To. Yes 2□ No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accidant 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 5.34 Physical Completely filled is 29e. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. edical (Check only 29b. Sign dure and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) OME) 015 236 may 11, 2000 1041 30. Nema and addrass of person who completed cause of death (Nem 23a) (Type, Print).
CALL I. MANGOLU: MO. 11125 ROCKUILLE PINE, ROCKUILLE, MO 20852 5 31. Data filed (Month, Day, Year) 32. Registrar's Signature State 2000 MAY 15 Docks Registrar



State of Maryland / Department of Health and Mental Hygiene 00 17356

				Certificat	e of	Death			Reg	. No.	2 1	1000
	1. Decedent's Name (First, Middle, L.	ast)	1811	18311 17				2. Date of Month	Deeth	Day	Yeer	3. Time of Death
Physician	Luis Felipe Mart	inez						May	13.	2000	Teer	7:13 am
/Medical Examiner	4a Facility Neme (If not Institution, gi					4b. City, To	own, or Lo				y of Death	Tall Chill
LXammer	Holy Cross Hospi	t o 1				C + 1	· Cn	rina		Mont	0 0 m 0 30	
			(In yrs. lest birth	nday) If Unde	r 1 Yeer	Silve If Under	24 Hrs.	8. Date of	Birth	Mont	gomer 9 Birth	y plece (State or Foreign
Funeral Director		11X M 2□ F	~-	rs. Months	Deys	Hours	Min.	8. Date or (Month) Oct.	Day, 1	1912	Cou	ntry)
	212-02-3639 Usuel Residence of Decedent							occ.	0,	1714	Per	u
Pand # #	10a. State 10b. County		10c. City, Town	or Location			Lane.					10d. Inside City Limits
Aary Aary	Maryland Montgom	A 2017	Rockvil	1.								1 Yes 2 No
vith the Ma t or 28s-f e be notified Director	10e. Street end Number	ery	ROCKVII		Code				100	g. Citizen of	What Cou	ntry?
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frer death v r Reme 23 alost must Funeral	90 Monroe Street		Turnin (1.0	208		FI- O-	1-1-2 (0-	- 14 . V		SA	an Ameri	can Indien,
Pr de	11. Maritel Stetus	12. Wes Decedent E Armed Forces?		13. Wes Dece If Yes, spe	cify Cub	en, Mexica	n, Puerto	Ricen, etc.)		ack, White,	
ors after	1 Never Merried 2 Married	1 ☐ Yes 2 🗓 N If Yes, Give	lo	1 X Yes	2□ No	Specify.	Per	uvian	ı	Speci	y: Wh	ite
d b		Yeer or Detes:				200						
a Z I Z I 3-0 led within 72 ho tygiene. naturn nt, In Medical Completed	15. Decedent's E (Specify only highest gi	ducation rade completed)		Decedent's Usu (Give kind of wo	ork done	during mos	st of work	ing	16	6b. Kind of 8	Business/Ir	ndustry
d within giene.	Elementery/Secondery (0-12)	College (1-4or 5-		life. DO NOT u	se retire	d)						
	12		0c	eanogra	pher					overn		Peru
A aryland 2 should be filed and Mental Hygi Is marked other eumstic event, To Be Cc	17. Fether's Neme (First, Middle, Las	t)				18. Moth	er's Neme	(First, Mic	ddle, Me	eiden Sume	me)	
Went Went To I	Jose B. Martinez					Hern	nanci	a She	en			
Maryland 21215-UUZU rd 2 should be filed within 72 hours at th and Mental Hygiene. 77 Is marked other than "natural", or r treumatic event, in a Medical Entra To Be Completed by F	19a. Informent's Neme/Reletionship	(Type, Print)	19b.	Mailing Addres	s (Street	and Numb	er or Run	Route N	um <i>ber</i> , i	City or Town	n, Stete, Zij	p Code)
Destrimore, Maryland 2 permit. Peges 1 and 2 should be filed Department of Health and Mental Hyg Important; if item 27 is marked other any injury or other treumstic event, once. To Be C	Almira Martinez	/ Wife	90	Monroe	Str	eet #	312.	Rock	vi1	le. M	208	50
Dallimore, semit. Peges 1 ar Department of Hea mportant: If them in the luny or other ince.	20e. Method of Disposition		20b. Pleca of	Disposition (Ne	me of			Dete		0c. Location		
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- 402.0	1. Kegan	1//=/10	llan							-		g, MD 20901
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/Medical	Immediate Cause (Final		1 1 1								- 1	- 1
Examiner	disease or condition resulting in deeth)	a Intracer									1	5 hours
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A 00 00, artificate be executed ling physicien and e as the burlai-transit Medical Examiner	thet initiated events resulting in death) Last		Due to (or es e co	onsequence of)							1	
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eath certification of the second of the seco		<u> </u>										
. 0 00 2	Pert II. Other significant conditions	contributing to death bu	it not resulting in	the underlying	ceuse giv	ren In Pert	l.	23b.	Did tob	acco use c	ontribute i	to the cause of death?
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be de												
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or Attending after death. Director: After 3 in by the fune entification	3 Suicide 6 Could not determine	Zoe. Flece of inju	ry - At home, far	m, street, facto	y, office						nber or Ru	rel Route Number,
Direction of in b	4 Homicide	building, efc	. (Ѕреспу)					Chy 0	r Town,	2(6(6)		
To the Hospital or Attending P within 24 hours after death. To the Funeral Director After completely filled in by the funeral Medical Certification:	29a. Certifier 1X Certifying P	hysician: To the best o	f my knowledge.	deeth occurred	et the ti	me, date e	nd pleca.	end due to	the ceu	use(s) and r	nenner es	stated.
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4	30. Name end eddress of person who	completed cause of de	eath (Item 23a) (Type, Print)	10	DI	TA	1 10		(1)	1.1	IND
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Registrar	мду 162	2000 Asene	var 1	J. 11	ack	2/						



Hospital within 2.

State

(Check only one)

29b. Signeture and title o

d add

Day, Year)

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Registrar **DHMH 16 Rev 6/95**

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is of person who completed ceuse of death (frem 23a) (Type, Print)

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32. Registrar's Signature

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2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) end menner steted.

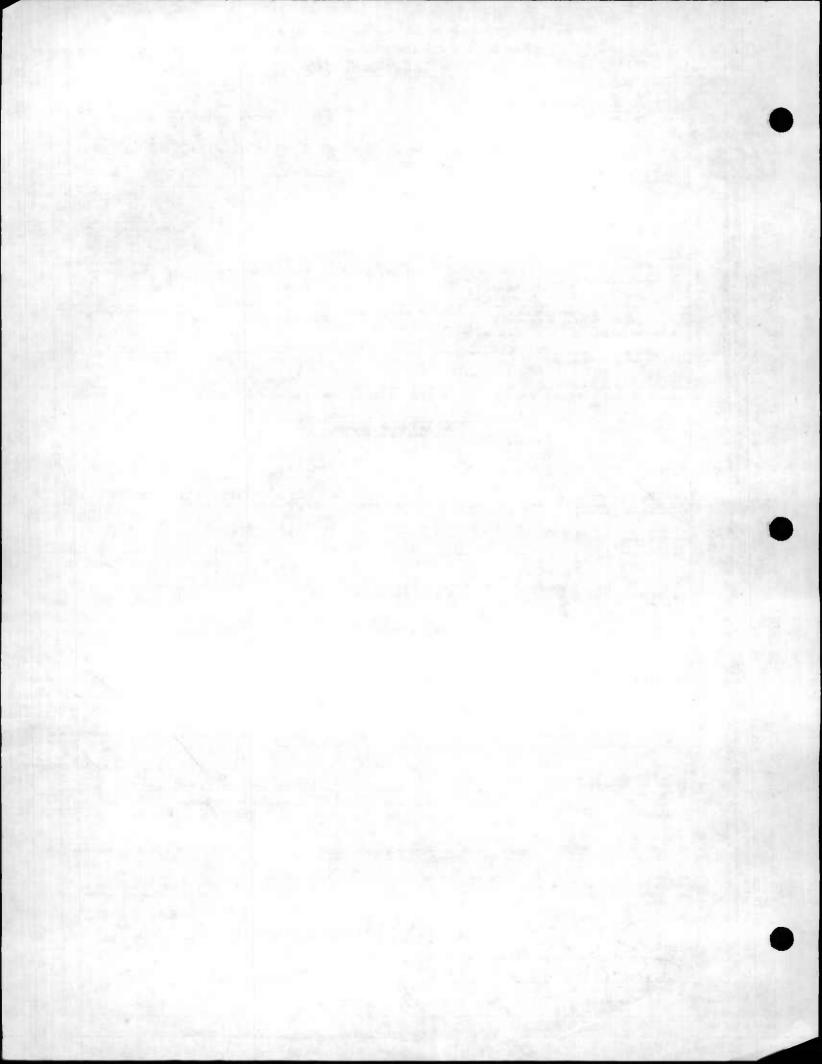
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Dete signed (Month, Day, Year)

May 17, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Moy Mary Gertrude McGuinness 3:00 PM 3000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner BIVER Spring Holy Cross Hospital 5. Sociel Security Number 6. Sex 8. Date of Birth (State or Foreign May 29, 1924 Washington D.C. If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 1□M 20 F Hours Days Months 215-44-2559 Usual Residence of Decedent 75 Yrs Director with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. instda City Ltmits pemit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Mantaomeru Spring 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 3040) 13. Was Decedent of Hispanto Origin? (Spectfy Yas or Notf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 10213 Grain Avenue Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 Yes 2 M No If Yas, Give/ Yaar or Dates: 14. Race - Amarican Indien, 11. Meritel Stetus Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Baltimore, Maryland 21215-0020 Specify: Specify: White py 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Housewife Homemaker 12 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Father's Name (First, Middla, Last) Be McNalle Mary Angela Pope Jacob Carl 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Silver Spring HD 20901 Data | 20c. Location - City or Town, State Elizabeth McGuinness/Munter Indian Spring Drive 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 1 Durial 2 Cramation 3 Removel from State 4 Donatton 5 Other (Specify) Amtomic Gift Foundation 5/15/00 22. Name end Addrass of Facility Anatomic Gift Fondal 13948 Baltimer Alence 21. Signature of Funeral Service Licensea 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Daath **Physician** /Medical immediate Cause (Finel 10500515 disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner Renal Stage sician and burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting to deeth) Lest Dua to (or as a consequence of) physician s the burial Box 68760 Physician/Medical Dua to (or es a consequance of): 950 23b. Did tobacco use contribute to the cause of death? ed by the e Part II. Other eignificant conditions contributing to death but not resulting to the underlying cause given in Part I. Division of Vital Records, P.O. signed by 1 Yes 2 No 3 Probably 4 Unknown Arrhythmia by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Senile dementia 200 No 1 Yes ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case refarred to madical axaminar? Be 26. Place of Death (Check only one) axaminar? 1 ☐ Yas 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how tnjury occurred al or Attending F s after death. 1 Naturat 2 Accident 5 Panding invastigation 1 Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicide To the Hospital o Certifying Phyelcfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar completely

State Registrar 29b. Signature and tittle of certifier

inda Bunner

31. Data filed (Month, Day, Year)

30 Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

2000

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Medical

32. Registrar's Signetura

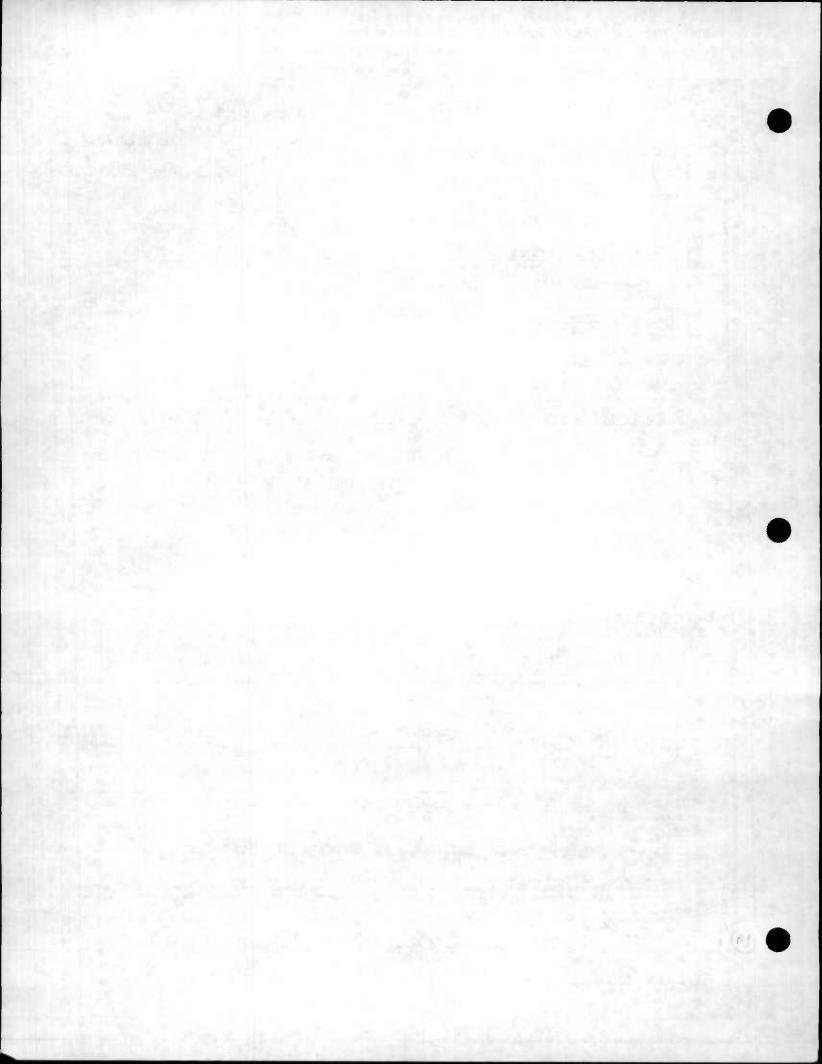
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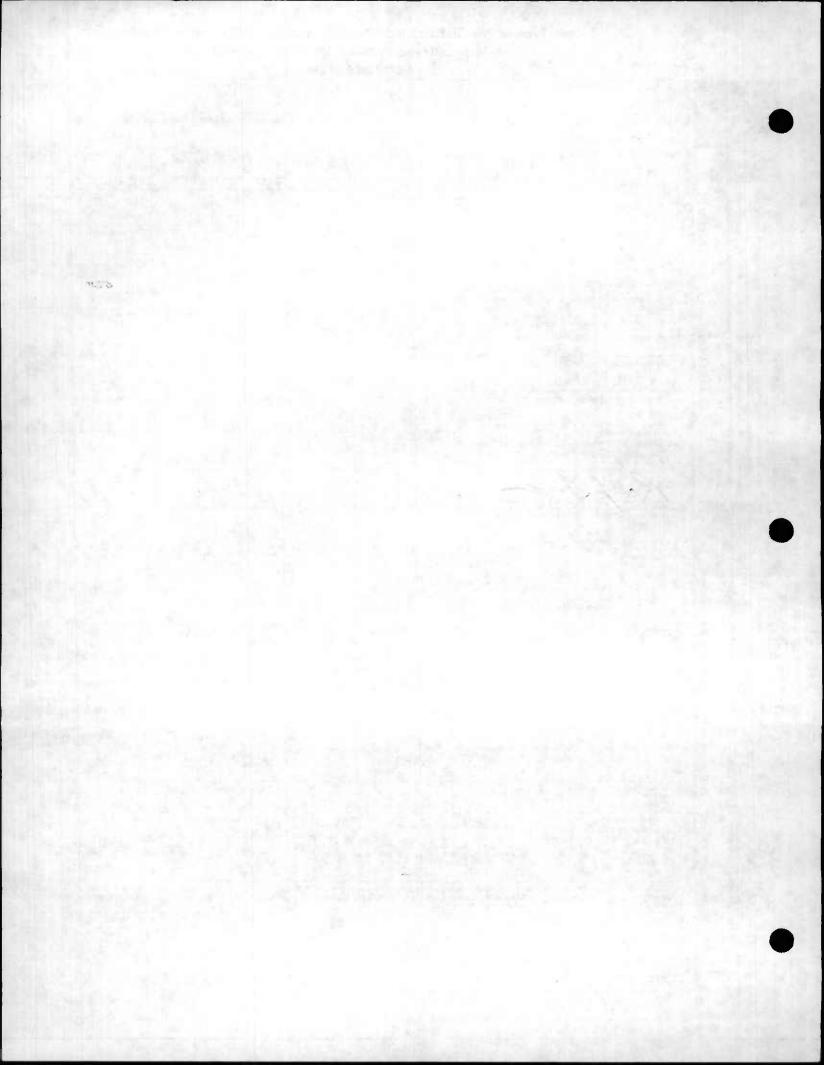
29c. Licansa number

Park Drive Ste 210 Silverspring MD 20902

29d. Data signed (Month, Day, Year)

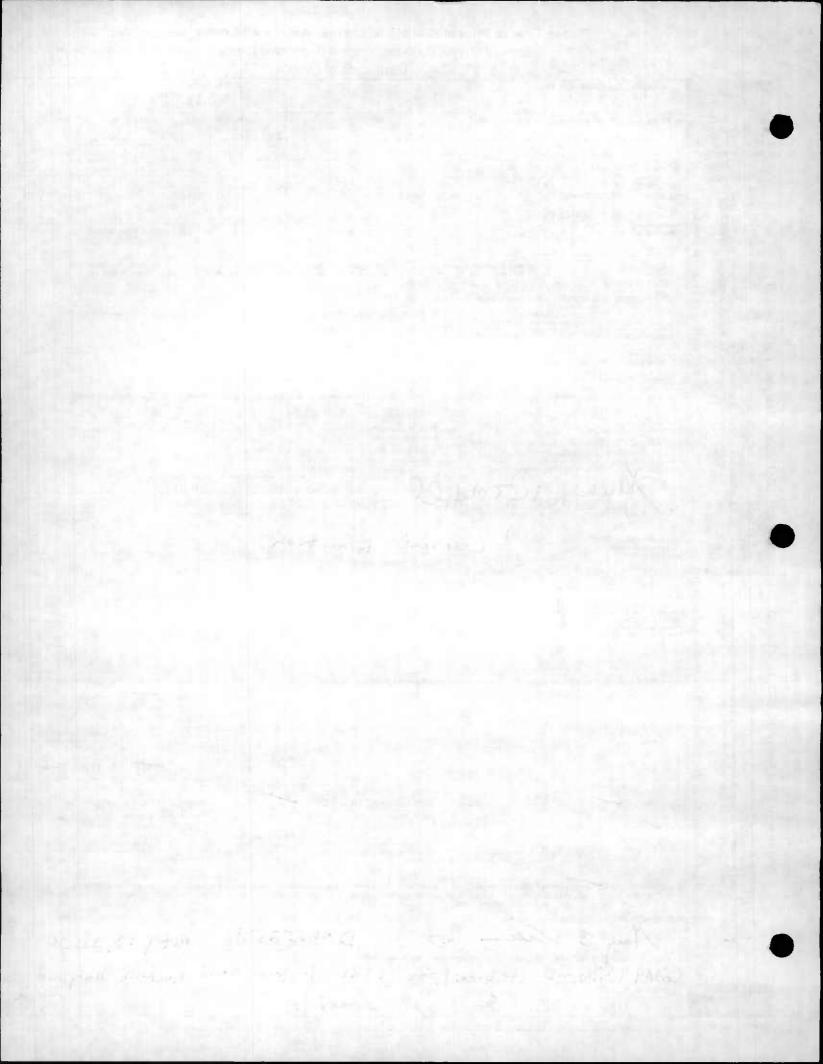


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important; it tem 2 is married other train "harters", or flema 23s or 28s-1 anow eny injury or other trainmade event, the Modified Enauther must be notified at once. To Be Completed by Funeral Director	3 ☐ Widowed 4		12, Was Decedar Armed Forca: 1 Yas 2 HYas, Giva Year or Datas	i? INo		Vas Decada i Yas, specif	nt of Hispanic Origin? y Cuban, Mexican, Pu ☑ No Specify:	(Specify Yas or N arto Rican, atc.)	14. Raca Black Specify:	A - American Indian, k, Whita, etc.
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State of Maryland / Department of Health and Mental Hygiene

360 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 13, Day 000 **Physician** Irene Minsker 7:40 AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery 9. Birthplece (State or Foreign Country) New York, NY If Under 1 Year if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec. 20, 1910 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 053-09-9267 89 Yrs. Director Usual Residence of Decedent pemit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□Yes 2₽No Montgomery Rockville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 Funerai USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☒ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Sacondary (0-12) 12 College (1-4or 5+) Secretary Temp Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Miller Jennie Suchin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numbar, City or Town, State, Zip Code) 200 SE 15th Road 15-J Miami, FL Joel Minsker - Son 20b. Placa of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Data 20c. Location - City or Town, State O' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeside Memorial Park 5-14-00 Miami, FL 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310 er the disease, of complications that causad tha daath. Do not entar tha moda of dying, such as cardiac or respiratory arrest, haart failura. List only ona cause on aach lina. Approximete Interval Between Onsat and Daath Plaint, En shock, or **Physician** Infarction /Medical Immediate Cause (Final Cerebral disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner ettending physician end for use es the buriel-trensit The law requires that the deeth certificate be executed Sequantially list conditions, it any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): the Part II. Other significant conditions contributing to death but not resulting in the undariying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detech 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy Completed After this certificate has funeral director, page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding deeth. 1 ☐ Yes 2 ☐ No Investigation 2 Accident after deet Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 5 4 Homicida 5 within 24 hours aft To the Funeral Di completely filled In 29a. Cartifiar 1 Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 0 0022928 MO 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Road Rockville, Maryland e brew Home 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar 2000



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Deeth **Physician** Month May 14, Clarence Dishmond Millner 2000 1:50 AM /Medical 4a. Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Rock Spring Village Forest Hill Harford If Under 1 Months 5. Social Sacurity Number If Undar 24 Hrs. 7. Age (In yrs. last birthdey) 8. Deta of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days **№** M 2□ F Yrs. 212-03-2408 89 Director July 14, 1910 Virginia Usual Rasidance of Decedent the Manyland 10a. Stata 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas XXNo Director Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? death with 10833 Sandringham Rd. 21030 USA Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Important: If Rem 27 Is marked other than "natural", or its 1 ☐ Naver Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3€ Widowed 4 Divorced Yeer or Detas: Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind ot Business/Industry Elemantary/Secondery (0-12) Collega (1-4or 5+) Route Salesman 11 Dairy Company 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Jesse Nollie Millner Cora Bell Clator 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 10833 Sandringham Rd., Cockeysville, MD 21030 Alice L. Kovens/ Daughter 20b. Place of Disposition (Nema of camatary, cremetory or other plece) 20a. Mathod of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Removal trom Stata 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp.

22. Name end Addrass of Facility 5-18-00 Towson, Maryland 21, Signature Funeral Service McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 math. Do not antar tha moda of dying, such as cardiec or respiratory errest, Approximete interval Between Onsat end Death Physician PROSTATE CANCER Immediate Cause (Final disease or condition resulting in death) Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiate cause. Entar Underlying Cause (Disease or Injury that initiated avants rasulting in daath) Lest Dua to (or as a consequence ot): and physician a a the burlat-Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy tindings available prior to 24a. Was an autopsy performed? Completed peed complation of cause of daath? s certificate has b director, page 2 s 1 ☐ Yes 2 DNo 1 Yas 2 No director, Be 25. Wes casa ratarred to medical examiner? 26. Placa of Deeth (Check only one) Othar: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of injury (Month, Day Year) funeral 27. Menner of Death 28b. Tima ot 28c. injury at Work? 28d. Dascriba how injury occurred After 1 Natural 5 Panding death. 1 TYas 2 No thin 24 hours after death. the Funeral Director: Ampletely filled in by the fun invastigation 2 Accident 6 Could not be datermined 3 ☐ Sulcida 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida Medical 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledga, daath occurred at the time, dete end piece, and dua to tha cause(s) and manner as stated. (Check only 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and two of cartitian 29d. Data signed (Month, Day, Year) 31775 2000 Mos BELAIR ROAS and address of person who completed cause of death (Itam 23a) (Type, Print) mARTLAND 32. Régistrer's Signatura State Registrar

where I was promise you

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene mend #2.3.5/26/2000, BMW, Montg. Co.
1. Decedent's Nama (First, Middla, Last) Certificate of Death 2. Data of Death Tima of Death 10:05 PM Day Month 11 **Physician** Ruben Dario Morales 2000 3:30 am /Medical May 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Takoma Park Washington Adventist Hospital Montgomery If Under 1 Yaer 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□ F Yrs. Director 578-76-2775 Usual Rasidence of Decedent 56 May 24, 1943 Colombia 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director 28a-f notifie Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code the Medical Examiner must be Berns 23a Funeral 11653 Lockwood Drive #202 20904 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, Whita, atc. 72 hours after Never Married 2☐ Married 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Datas: Baltimore, Maryland 21215-0020 natural, or 1☑ Yes 2☐ No Specify 3 ☐ Widowed 4 ☐ Divorced Colombian White Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) filed within Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) 12 Mail Clerk Private parmit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If Nem 27 is marked othe any injury or other traumatic event any injury or other traumatic event and solution. 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Efigenia Morales Laurentino Morales 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 11653 Lockwood Drive #202 Silver Spring,MD 20904 Jorge Morales (brother) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 5/15/00 Silver Spring, Maryland 21. Signature of Funeral Servica Licensaa 22. Nama and Addrass of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Approximata Intervel Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disaasa or condition rasulting in death) /Medical Examine Examiner buriel-transit certificate be executed pue Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Diseese or Injury attending physician of for use as the buriel Box 68760 Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? by the 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy peen : DINO 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Wes casa rafarrad to medical B 26. Placa of Death (Check only ona) examinar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Deeth 1 Le Netural 28a. Data of Injury (Month, Day Year) 28c. tnjury et Work? 28d. Describe how injury occurred 28b. Tima of 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicida

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29a. Certifier

29b. Signetura and titla of cartille

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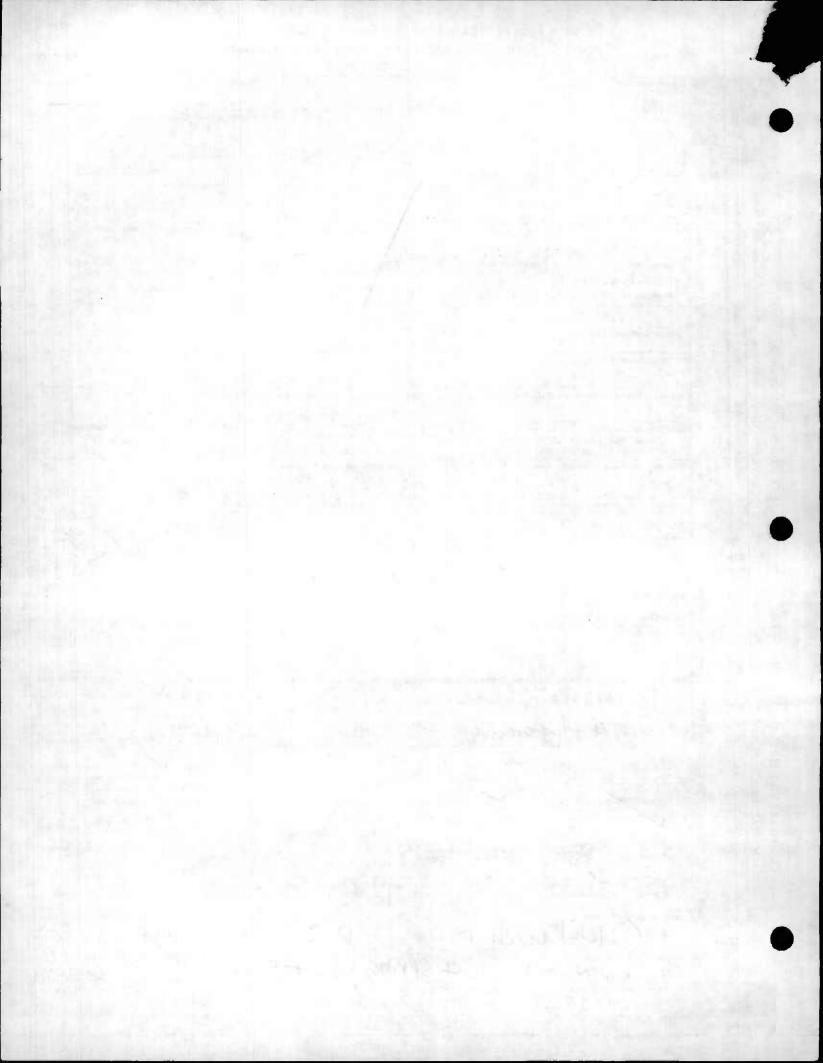
State Registrar

29c. License number

1 Certifying Phyeician: To tha best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29d. Data signed (Month, Day, Year)

KWON 31. Data filed (Month, Day, Year) 32. Registrar's Signature



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death MYERS Month Physician LILLIAN May 16, 2000 11:30 AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, July 4, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 SF Yrs 071-10-8337 82 1917 Pennsylvania Director Usual Residence of Decedent with the Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or flems 23s or 28s-f short the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Funeral Director Montgomery Silver Spring 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 20906 12109 Veirs Mill Road United States 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examinations. 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry L. Eck Lillian Busse 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19s. Informent's Name/Relationship (Type, Print) 12109 Veirs Mill Rd., Silver Spring, Maryland 20906 Susan S. Sumner/Daughter 20b. Place of Disposition (Name of May 22, 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ₺ Burial 2 Cremation 3 Removal from Stete Ft. Lincoln Cemetery 2000 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) RôberêndAddror ûnfelley Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M00198 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** CARDIOGENIC SHOCK /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner CORONARY ARTERY DISEASE ician end burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): CARDIOVASCULAR DISEASE physician the burial Box 68760, Physician/Medical Due to (or as a consequence of): 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? P.O. BRAIN SYNDROME, 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to Completed completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 20 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Certification: 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

State Registrar

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29a. Certifier (Check only one)

30. Name and add

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) 17

2000

person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

Eneva

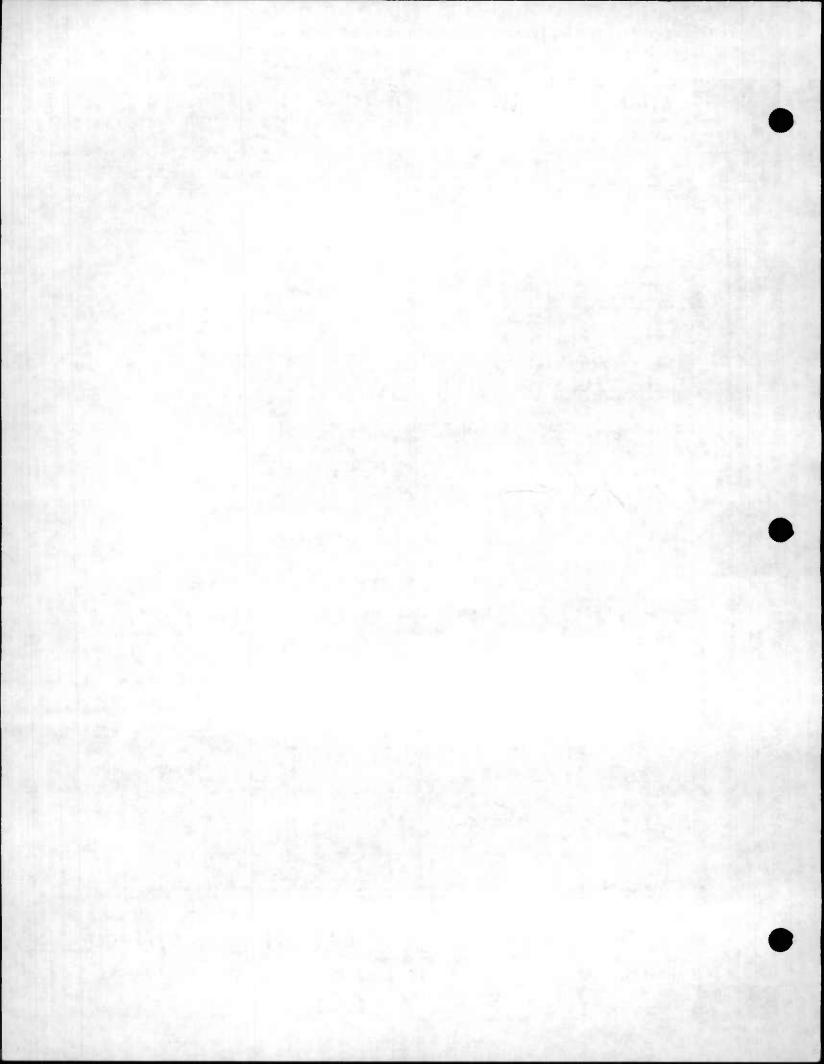
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Day, Year) 161

AVE, BETHESDA, MO 20814



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year NORRIS MAY 19 2000 1 HOMAS 68.10 A 4a Fecility Neme (If not institution, give street end number) 4b, City, Town, or Location of Death 4c. County of Deat ANNE HRUNDEL Anne Arundel Medical Center HNNAPOUS ff Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Months Deys Hours Min. July 26, 1926 Birthplace (State or Foreign Country) Mary Land 5. Sociel Security Number 7. Age (In yrs. lest birthday) 1 M 2□ F Months Yrs. 220-12-8749 73 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 22 Brice Road 21401 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☑Yes 2 ☑ No If Yes, Give Yeer or Detes: ₩₩☐ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Banker Finance 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Thomas Norris Margurite Yienger 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Regina Norris/ Wife 22 Brice Road Annapolis, Maryland 21401 20b. Plece of Disposition (Name of numetery, cremetery or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 05-24-00 Brentwood, Maryland Lincoln Crematory sture of Funeral Service Licer 22. Neme end Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Maryland 21401 thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth EMORRHAGE NTRACRANIAL Due to (or as a consequence of) HTRIAL FIBRILLATION L YEARS Due to (or es e consequence of): HRIERY ISEASE YEARS DRONARY Due to (or es e consequenca of) ABETES TYPE Two 10 YEARS 23b. Did tobacco use contribute to the cause of death? t ☐ Yea 2 ☐ No 3⊠Probably 4 Unknown HYPER KALEMIA

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Important if them 27 is merked other than "natural", or the any Injury or other trauments event, the Medical Examines.

Baltimore, Maryland 21215-0020

Immediete Ceuse (Finel diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. YPONATREMIA 24e. Wes en eutopsy ONGESTIVE POTHYROIDISIM 1 ☐ Yes 2 No

Physician/Medical Examiner use as the buriel-transit After this certificate has been signed by funeral director, page 2 should be detact Be Completed by Certification: To filled in by

or Attending Physician: The law requires that the death certificate be executed

After this certificate

after deeth.

24 hours a Hospital

To the To the To the F

completely

P.O. Box 68760.

Records,

Division of Vital

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

FAILURE 25. Wes case referred to medical examiner?

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Inpatient 2□ ER/Outpatient 3□ DOA

1 Yes 2 No 27. Menner of Deeth

28e. Dete of Injury (Month, Dey Year)

28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

18 Neturel 2 Accident 3 Sulcide

4 Homicide

5 Pending Investigation 6 Could not be determined

1 Yes 2 No 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

alherine

MAY 2 2 2000

29c. License number 53450 29d. Date signed (Month, Day, Year) 2000

KATHERINE

Medical

DINIEAVY 31. Dete filed (Month, Day, Year)

30. Name and address of parson who completed cause of deeth (Item/28a) (Type, Print) OLD SOLDMANS ISLAND ROAD FINNAPOLIS 139 3. Registrer's Signeture

untano

State Registrar

1988 8 8 40 M

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Midgle, Last) 2. Date of Death 3. Time of Death **Physician** Velsor ay 5:10 Vaughn /Medical 4c. County of Death 4a Factity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Undar 24 Hrs. 8. Date of Birth Month, Day Year May 6 1938 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Houra Months 1 M 2 □ F 522-44-2230 62 Kansas Director Uaual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or herma 23a or 25a and 1000. 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 TYAS 2 NO **Funeral Director** MD Howard Columbia 10f Zin Code 10g. Citizen of What Country? 10e Street and Number 6725 Quiet Hours 21045 U.S.A. 12. Was Decedent Ever in U,S. Amed Forcas? 1 B Yes 2 □ No If Yes, Give Yaar or Datas: 14. Race - American Indian, Black, White, etc. Waa Decedant of Hispanic Origin? (Specify Yes or No-tif Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11 Maritat Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Geodetic Elementary/Secondary (0-12) College (1-4or 5+) Survey field engineer 18. Mother'a Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Loftus Virgil Nelson 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karel Nelson, wife 6725 Quiet Hours, Columbia, Md. 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arlington National Cem. 5/30/00 Arlington, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licans 22 Name and Address of Facility Witzke Funeral Homes, Inc. M00 741 5555 Twin Knolls Rd., Columbia, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, abook, or heart failure. List only one cause on each line. Approximate tntervai Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner attending physicien end for use as the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to Immadiate ceuse. Enter Undarlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 ☐ Yea 2 ☐ No

1 Yes 2 17 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yea 2₽ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 3 Suictde 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier

(Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of person why completed cause of death (Item 23a) (Type, Print)

CARMEN SALVATERRA M.D. 10724 Little Patuxent Pkwy, Columbia, Md. 21044

State Registrar

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Completed

Be

Certification: To

Medical

4 Homicide

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After this certificate has

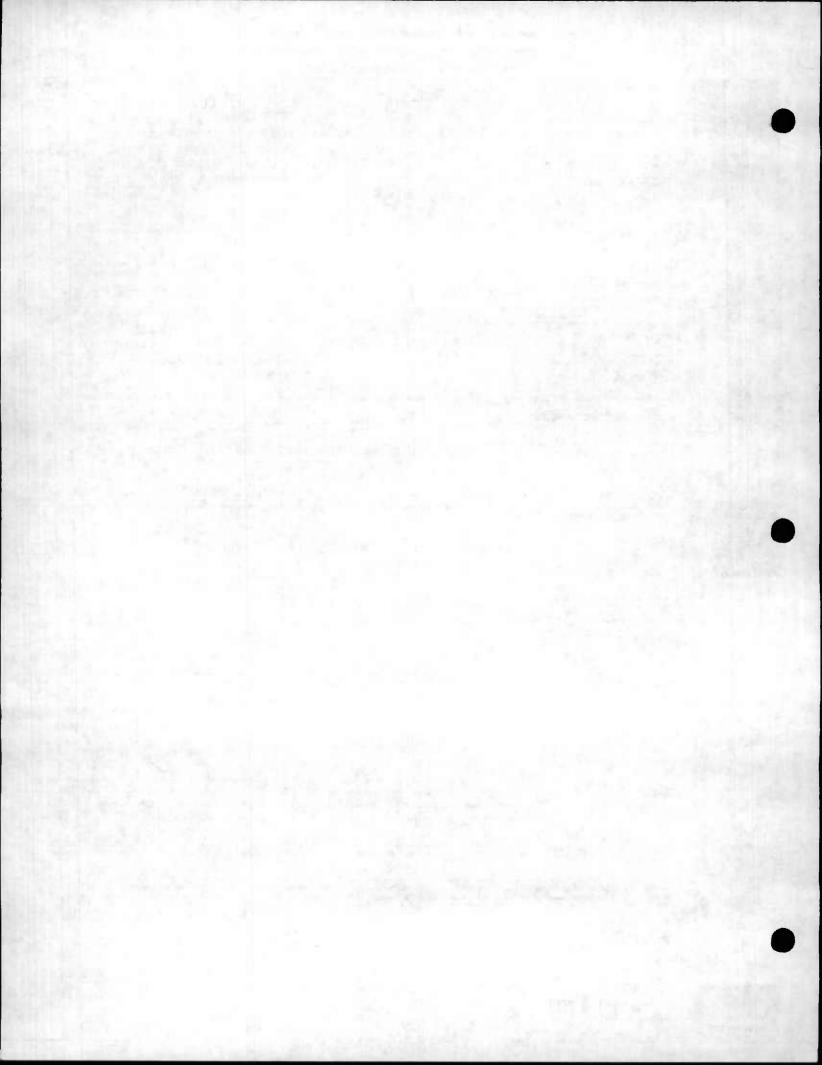
I or Attending Physician: ster death. eral Director: After this certificatilled in by the funeral director.

Hospital of 24 hours a To the Hospital within 24 hours a To the Funeral Completely filled

> 31. Date filed (Month, Day, Year) MAY 1 6 2000

32. Registrar's Signature Darks

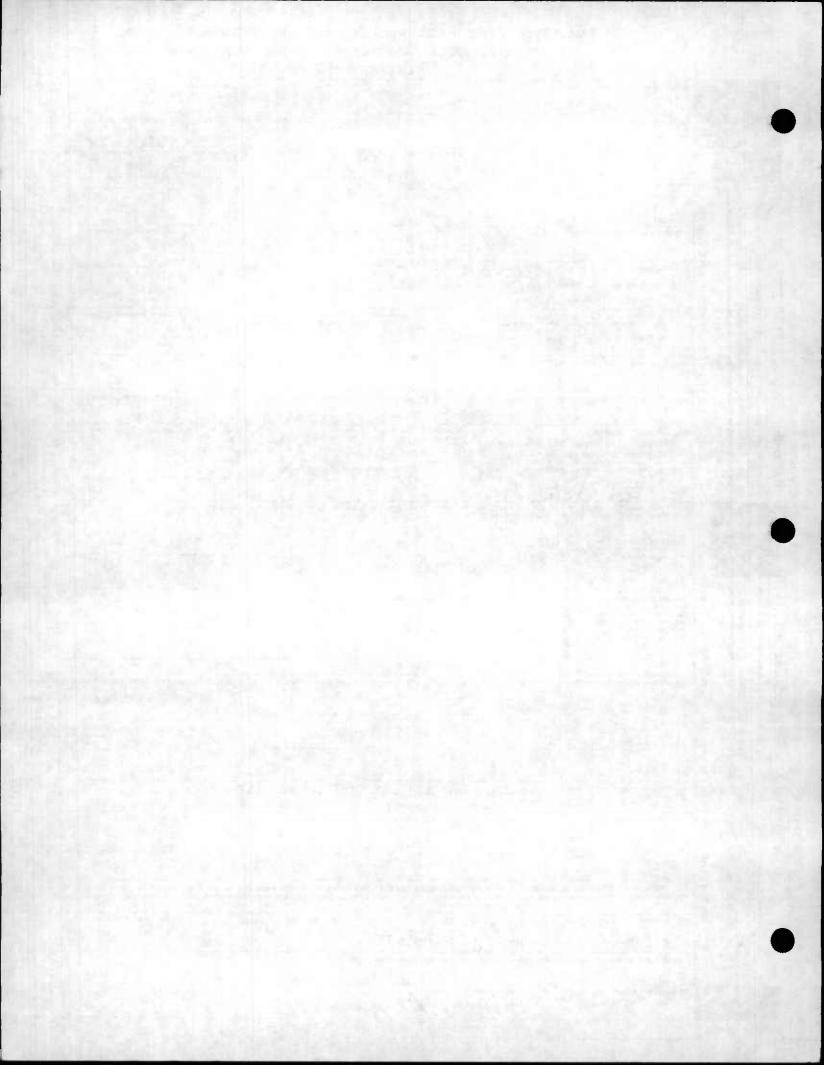
Division of Vital Records,



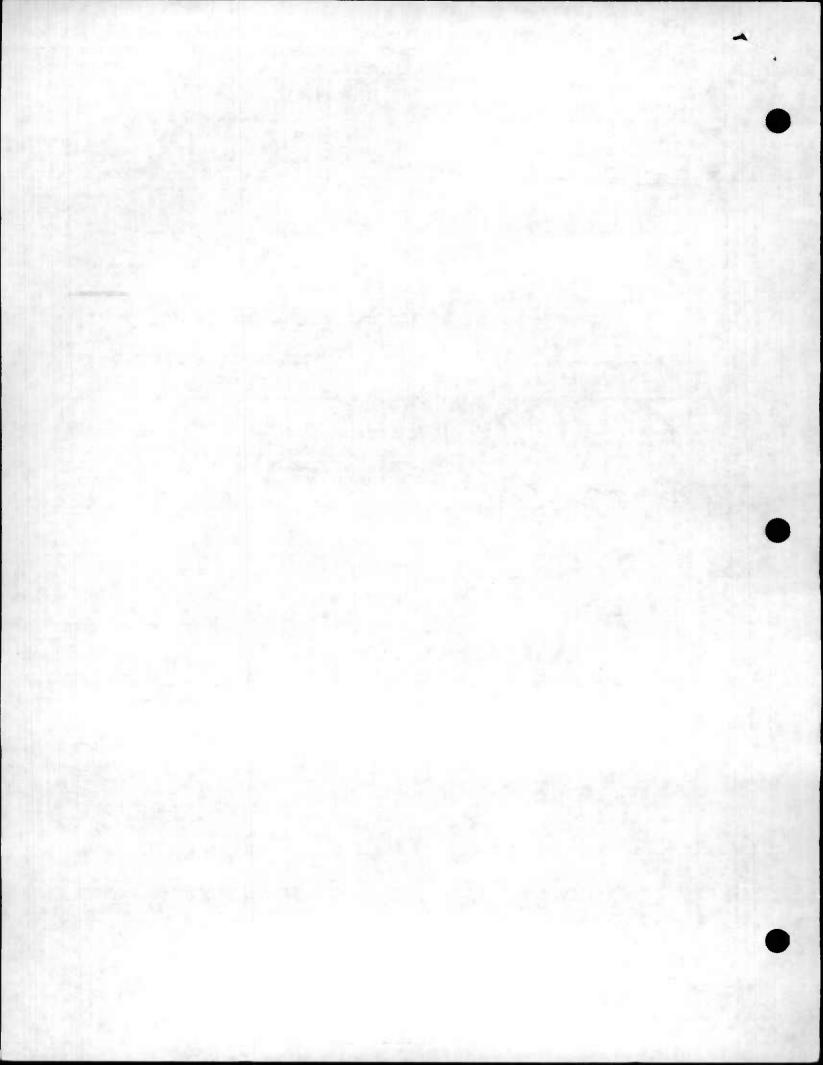
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State of Maryland / Department of Health and Mental Hygiene	00	,
Certificate of Death Reg. No.	UU	1

				Cei	rtificate of	Death		Reg. No.	00	1/366		
	1. Decedent's Neme (First, Middle,	2. Date of D		Year	3. Time of Death							
Physician /Medical	Perry Joseph Nic	kles					May 1			2:35 pm		
Examiner	4e Facility Neme (If not institution,	CONTROL PURSUE OF THE CO.	er)			4b. City, Town, o	or Location of Dec	eth 4c. Cou	inty of Deeth			
Examine	12715 River Road					Potomac		Mont	tgomer	v		
Funeral		. Sex 7.	Age (In yrs. la	st birthdey)	If Under 1 Yeer	If Under 24 H			9. Birth	plece (State or Foreign		
Director	298-05-0269	1፟፟፟M 2□ F					in. (Month, I	8. Dete of Birth (Month, Dey, Year) Nov 7, 1909 9. Birthplece (State or Incomplete) Country) Ohio				
	Usuat Residence of Decedent						100 7, 1909 01120					
72 hours after death with the Maryland natural, or Herna 23a or 28a-f abow occur Examiner Insat be notified a sted by Funeral Director	10a. Stete 10b. County		10d. Inside City Limits									
Very	Manyland Mantaga					1 ☐ Yes 2 No						
or 28a-fa be notified Director	Maryland Montgon	lely	nery Potomac 101. Zip Code						10g. Citizan of What Country?			
The nours are death with the weigher "natural", or flower 23a or 28a-f above often Examiner must be notified at letted by Funeral Director.	12715 River Road	10 Mar Danada	tionanla Orlain?	(Chasibi Vas as B	USA	Rece - Ameri	cen Indien					
E E	11. Merital Status	12. Wes Decede Armed Force 1 Yes 2	95? 	13.	Wes Decedent of I If Yes, specify Cub	en, Mexican, Pu	erto Ricen, etc.)	14.1	Bleck, White,			
by F	1 Never Married 2 Merried	If Yes, Give			1□ Yes 2 X No	Specify:		Spe	ecity: Wh	ite		
d b	3 Widowed 4 Divorced	Year or Dete	es:									
ygiene. Ne than "naturn n, m. Neotcall Completed	15. Decedent's (Specify only highest)	Education grade completed)		16a. Deced	dent's Usuel Occu kind of work done DO NOT usa ratire	pation during most of v	vorking	16b. Kind o	of Businass/In	idustry		
	Elementary/Secondary (0-12)	College (1-4										
on, per than		5+		Vice I	President			Const	ructio	n		
Se ver	17. Father's Neme (First, Middle, La	st)				18. Mother's N	leme (First, Midd	le, Malden Sun	neme)			
metic e	Nicola Nickles					Elizab	eth Rae					
5	19e. Informent's Neme/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	t end Number or	Rurel Route Nurr	Rurel Route Number, City or Town, State, Zip Code)				
ant: If them 27 is marked ury or other traumatic e TO E	Nina Nickles/ W	Vife	-	1271	5 River I	Road. Po	tomac. M	ID 208.	54			
4	20e. Method of Disposition	1220	20b. Pie	ece of Dispo	sition (Neme of		Dete		on - City or T	own, Stete		
de	1 Buriel 2 □ Cremetion 3		916		matory or other ple		E /17/00	0:1	C	MD		
important: If Iten any injury or oth once.	4 Donetion 5 Other (Spe		Gat		Heaven Co		5/17/00	Silve	r Spri	ng, MD		
ny ic	21. Signeture of Funerel Service	pensee /		F1	2. Neme end Addr rancis J	Collin	s Funera	1 Home	, Inc.			
- a a	X (1)	timed								g, MD 2090		
	23a. Part1. Enter the disease, or co shock, or haart feilure. List or	mplications that cau	sed the death.							Approximate Interval Between		
ician	SHOCK, OF HEART ISHING. LIST OF	ny one ceuse on eec	iiiio.							Onsat and Death		
dical	Immediate Causa (Finel				** . 1				1			
iner	diseesa or condition resulting in death)	a. Conges			Failure				1			
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is in		Aortic	Valve						1			
Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Entar Underlying		Dua to (or	es e consac	quence of):							
<u>=</u>	Cause (Disease or Injury	C							i			
edicai	Cause (Disease or injury thet initieted events resulting in death) Last Due to (or as e consequence of):											
se as the burial-transit vMedical Examir												
3 6		0.							1			
d be detached for	Pert II. Other significant conditions	contributing to deat	h but not resul	iven in Pert I.	23b. DI	contribute	to the cause of death					
etached for u Physician	The second secon					11	1 Yes 2 No 3 Probably 4					
be det		Jisease	_	10.10								
D D							24a. W	es an autopsy		Vere autopsy findings		
should							pe	rlormed?	C	vaileble prior to ompletion of cause		
8 0 C								\.v		f death?		
Com				1000			10	Yes 212N	1	☐ Yes 2☐ No		
director, pag	25. Wes case referred to medical examiner?		1 1 1 1				Deeth (Check on)	y one)				
9 5	1 ☐ Yas 2 🗖 No	Hospitel: 1 🗆 Inp	atiant 2 E	R/Outpatier	nt 3 DOA	her: 4 Nursin	g Home 5 Re	sidence 6	Other (Spec	ify)		
3 08	27. Manner of Death	28e. Data of (Month.	28e. Data of Injury (Month, Dey Year) 28b. Time of Injury 28b. Time of Injury 28c. fnjury at Work?					28d. Describe how injury occurred				
atic	2 Accident investiga	M 1 Vec 2 No										
ific by	3 Suicide 6 Could not be detarmined 28e. Plece of Injury - At home, ferm, streat, factory, office building, atc. (Specify)								umber or Ru	rei Route Number,		
led in by the funera Certification:	4 LI Hollicide	building	, atc. (Specily)	,			Ony or I	City or Town, State)				
completely filled in by the funeration:	29a. Certifier 1 X Certifying	Physician: To the be	est of my know	riedne, deeti	h occurred at the t	ime, dete end ple	ece, and due to the	na causa(s) en	d menner as	stated.		
pletely fill edical	(Check only 2 Medical Ex	aminer: On the basi	s of examineti									
M M	29b. Signeture and title of certifier	A.	olulus.		29c, Licen	se nu <i>m</i> ber		29d. Dete si	igned (Month	, Day, Year)		
	A BO	11.	~	74.								
,	- Warle	morr	0	mi	D 14	364		May 15	, 2000			
	30. Name and address of person wi	no completed cause	of deeth (ftem	23e) (Type,	Print)				75			
	M.H. Chaudhry,	MD 7610 (Carroll	Ave.	, #300,	Takoma F	Park, MD	20912				
State	31. Dete filed (Month, Day, Year)		Istrer's Signet		1	7 - 1 - 1 - 2		-111				
otate Rentzinas	MAY 162	000 60	was	19.	book							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #14 PER FH G784 6/2/2000 AH 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month **Physician** 2000 May 7:37 AM John Marshall /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital If Under 24 Hrs. If Under 1 Year 8. Dete of Birth 9. Birthplaca (Steta or Foraign (Month, Day, Year) Nov. 28, 1906 North Carolina 9. Birthplaca (Steta or Foraign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Hours Months Min. 1 M M 2□ F 93 Yrs 102-03-8889 Director Usual Rasidence of Decedent with the Maryland 10a Steta 10c. City, Town or Location 10b. County 10d. Inside City I Imits I7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 210 No Maryland | Montgomery Silver Spring Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 20906 USA 2601 Bel Pre Road Funeral 12. Was Decedent Evar In U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11 Merital Status hours after 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 BLACK 1 ☐ Yes 2 ☑ No Specify: Specify: III þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry filed within 72 Hygiena. Collega (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental hygiens Important: If Item 27 is marked other that any injury or other traumatic event, 27 and once. Court System Clerical 12 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Sudie Noble Frank Nunn 10 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) T. Jeffrey Neal / Grandson 14920 Village Gate Drive, Silver Spring, MD 20906 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata Date 20a. Mathod of Disposition 1 ☐ Burial 2 GCremation 3 ☐ Removal from State Fort Lincoln Crematory 05/15/00 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Nama and Addrass of FacilityHines-Rinaldi Funeral Home 21 Signature of Furierel Service Licenses 11800 New Hampshire Avenue Silver Spring, Maryland 23a. Part1. Enter the disease, or complication, that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one minn on each line. Approximete Interval Between Onsat and Daath **Physician** /Medical Immediata Ceuse (Finet 5 days Staphylococcal Sepsis disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Examine Respiratory Insufficiency ician and burial-transit Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequance of): physician s the burial Box 68760. Congestive Heart Failure certificate be Physician/Medical Dua to (or as a consequence of): 98 Hypertensive Cardiomyopathy 0SD P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings aveilable prior to completion of ceusa of death? 24a. Was en autopsy performad? Completed peed has 1 Yas 2 No 1 ☐ Yes 2 ₩ No certificata 25. Was cesa ratarred to medical examinar? Be 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 10 1 ☐ Yas 2K No 1 🖾 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Mennar of Death 28a. Dete of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: al or Attending P s after death. I Director: After od in by the funer 1 Meturel 5 Pending invastigetion 1 Yes 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 I Homicida To the Hospital of within 24 hours a To the Funeral D completely filled in a second sec edical 29a. Certifier 1⊠ Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, deta and place, and dua to the ceuse(s) end menner as stated.
2 ☐ Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the causa(s) and manner stated. 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier May 9, 2000 D45285 30. Name and address of person who completed ceusa of death (ttem 23a) (Type, Print) 344 University Blvd., #113, SIlver Spring, Maryland J. Ninala, M.D. 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State MAY 1 souls Registrar



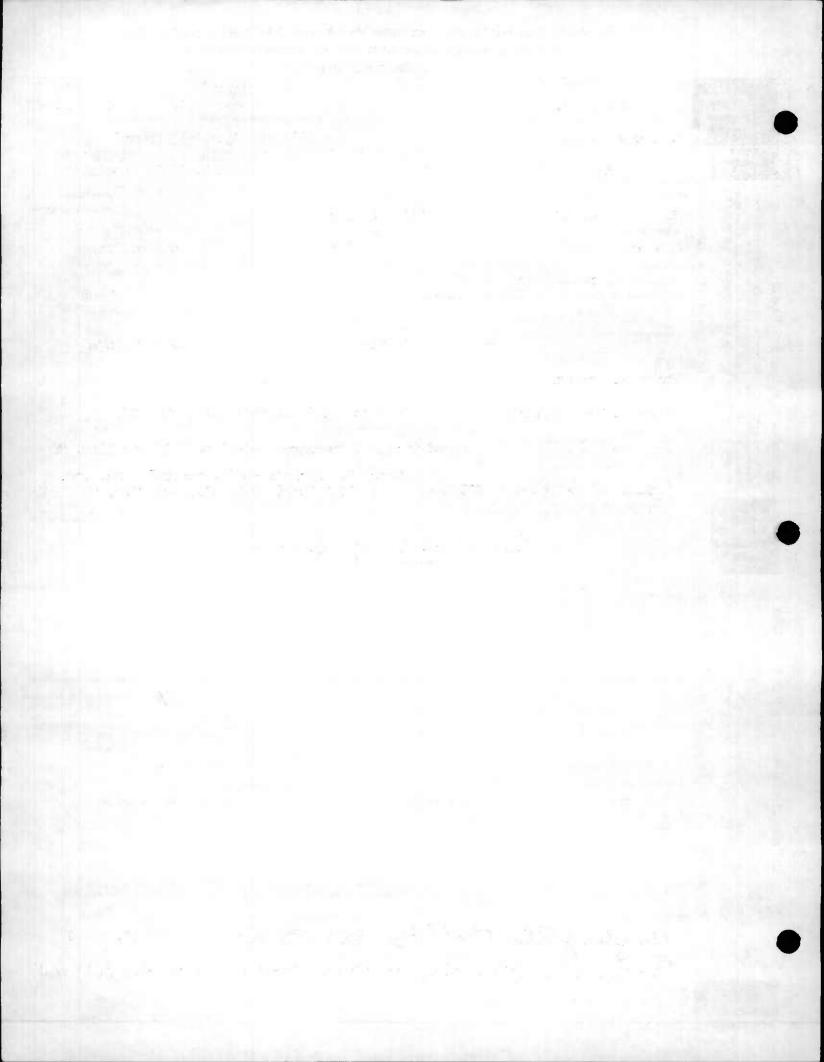
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name /First Middle Last) 2. Data of Death 3. Time of Death Year Month **Physician** Adrian J. Van Oss May 16 2000 9:30pm /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 8200 Tyson Road Ellicott City Howard 5. Social Sacurity Number If Under 1 Year ff Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 XM 2 F Yrs. 388 12 0654 Director 78 Dec 6, 1921 Louisiana Usual Residence of Decedent death with the Maryland 10a. Stata 10b County 10c. City. Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8200 Tyson Road 21043 United States 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Pages 1 end 2 should be filed within 72 hours etter enent of Health and Mental Hygiene.

The filed To marked other than "natural; or ite may or other than "natural; or ite ury or other traumatic event, I'm Medical Examina Affiled Forces: 1 XYes 2 □ No If Yes, Give Year or Dates: 1940-46 1 ☐ Never Married 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) 5+ Dentist Self Employed 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Adrian S. Van Oss Maud Inez Armigo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sh Department of Health and Important: If Itam 27 Is m any Injury or other traum once. Martha S. Van Oss/Wife 8200 Tyson Road Ellicott City, MD 21043 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 Removal from Stata Good Shepherd Cemetery 5-20-2000 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or haart failure. List only one causa on each line. Approximate Interval Batwean Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of Examine The law requires that the death certificate be executed the buriel-tran Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical Due to (or as a consequence of): ettending pl Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 □ Probabiy 4 □ Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 1 ☐ Yes 1 TYes 2 No 2 3 No of Vital or Attanding Physician: director, Be 25. Was cesa referred to medical axaminer? 26. Piaca of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) To the Hospital or Autorians, within 24 hours after death.

To the Funeral Director: After this c Certification: To 1 ☐ Yes 2 No 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Division 5 Pending Invastigation 1 Natural 1 ☐ Yas -2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide Kertifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as statad.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the causa(s) and manner stated. 29a. Cartifiar Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 17, 2000 30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print) 3449 Wilkens Are Balt mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 8 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.'

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** George Charles Prince, Jr. MAY 9, 2000 9:55 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 10 / 12 / 1918 9. Birthplace (Stata or Foraign Country) Maryland 5. Social Security Number 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Yrs. 212-03-3960 81 Director Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Directo 28a-f MD Harford Havre de Grace 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 'natural', or flams 23a or USA 118 Weber Street 21078 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yas 2 □ No If Yas, Giva Year or Dates: WW 2 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Custodian 8th 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be and 2 should be marked Susan Butterworth George Charles Prince, Sr. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) mportant: If Item 27 Agnes Mary Prince- Wife 505 Congress Ave., Apt. 304, Havre de Grace, Baltimore, Pages 1 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 1X Buriat 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Department of Erin Cemetery Mit. 5/12/00 Havre de Grace, MD 21. Signature of Funaral Service Licenses 22. Nama and Address of Fecility Mitchell-Smith Funeral Home, P.A. nutt 123 S. Washington, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical 4 WEEKS PNEUMONIA **Examiner** Dua to (or as a consequence of) Examiner attending physician and for use as the bunal-transit certificate be executed Sequantially list conditions, if any, teading to immadiata causa. Entar Underlying Cause (Disaase or thjury that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Yee 2 No 3 Probably 4 Unknown ped ped p Records, þ 24b. Wara autopsy findings available prior to complation of causa of daath? Completed 24a. Was an autopsy page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Be 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 10 1 Yas 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 1 Natural or Attending 5 Pending invastigation 1 Yes 2 No after deeth. 2 Accident Director: 6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide within 24 hours a To the Funeral D completely filled i the Hospital edical 29a. Cartifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) end mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number (Can MAY 9, 2000 D16608 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) KAM KEN LEUNG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 31. Data filed (Month, Day, Year) MAY 11 2000 32. Redistrar's Signatura State Registrar

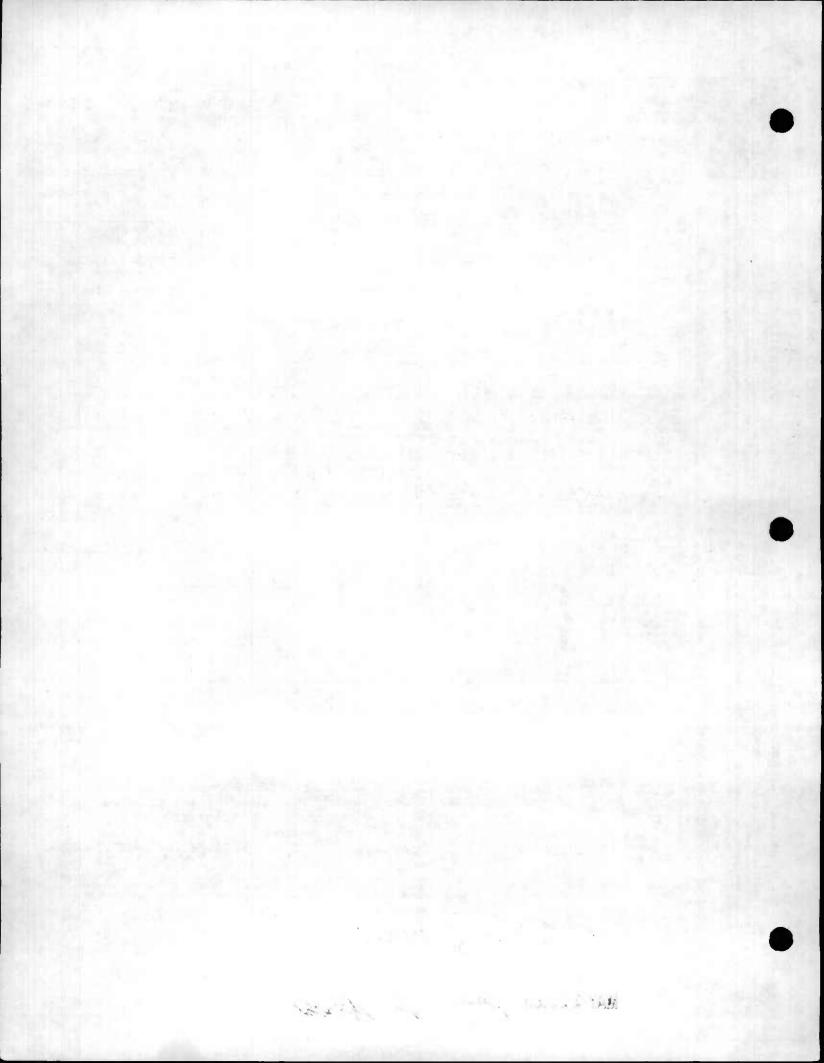
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PHYSICIAN:

KNOWN 0

PRINCE

GEORGE



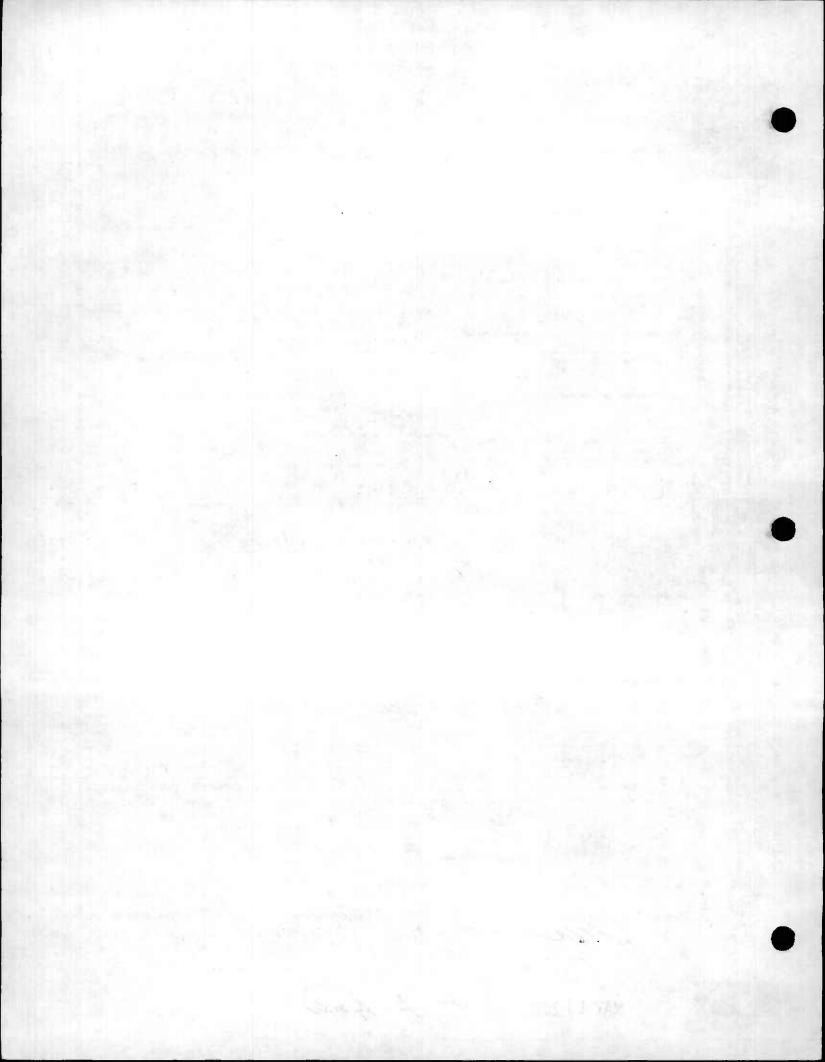
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2 Data of Death 3 Time of Death **Physician** May Edward 2000 John Piorek 5:55AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Northampton Manor Nursing Home H Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 5. Social Security Number 8. Dala of Birth (Month, Day, Year) Apr. 15, 1927 Birthplaca (State or Foreign Country) **Funeral** Days 1⊠M 2□F Yrs. 048-18-2757 Connecticut Director Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits "naturel", or items 23a or 28a-f show access Examiner must be notified at 1 X Yas 2 No Woodsboro Directo Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21798 U.S.A. 101 N. Main St. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ⊠ Yas 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian. 11. Marital Status Biack, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If New 72 Is merked other than "naturel, or Ne any Injury or other than the World Entities any Injury or other thaumatic event, the Model Entities. 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 If Yas, Giva Year or Dates: 1951-53 1 ☐ Yas 2 ☒ No Specify: White 3 2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) electrical technician electronics 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Sophia Wesolowski John Stanley Piorek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Absecon, NJ 08201 SFC Leonard J. Addis III/stepson 627 E. Biscayne Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 15/13/00 Woodsboro, MD Mt. Hope Cemetery 22. Nama and Address of Facility
Hartzler Funeral Home 21. Signature of Funeral Sarvice Licenses Harine 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Entar tha disease, or complications that cause in death. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on each in the shock of the Approximata Interval Batween Onset and Death **Physician** PROBABLE ASPIRATION PNEUMONITIS Immediata Causa (Final diseasa or condition rasulting in death) /Medical 2 Hours Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humaltoness. Sequentially list conditions, if any, leading to immediata cause. Enlar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Box 68760 Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CARABARI VASCULAR XELIORAN Records, þ 24b. Wara autopsy findings availabla prior to complation of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Be 25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No invastigation 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. 29a. Certifier (Check only one) 29b, Signature and file of certifier 29c. License number 29d. Dala signad (Month, Day, Year) 026499 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller 4 Culwell Dr. Mt. Airy, MD 21771 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth ELIZA BETH Month PETERS 2 AM 15 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BON SECOURS HOSPITAL BACTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Days Months 1 M 2 TF 220-24-9040 Baltimore MD Usual Residence of Decedent 10c. City, Town or Location
Woodlawn 10b. County 10d. Inside City Limits Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21207 Funeral 1436 Forest Park Ave. 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 3 Widowed 4 Dworced 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 No Specify: by SpecifyWhite Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Ratmond Donaldson Vera Carney 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen E. Peters - Husband 1436 F 20b. Placa of Disposition (Name of Date 20c Location City of Date 20a. Method of Disposition 20c. Location - City or Town, State cemejery, crematory or other place)
Lakeview Me
morial Park 1 Burial 2 □ Cremation 3 □ Removal from State 5/19/2000 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Witzke Funeral Home of Catonsville, MD 21228 23a. Part 1 Enter the drease, shock, or heart fature. 1 and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. PNEUMONIA ASPIRATION Immediete Ceuse (Final disease or condition resulting In death) Due to (or as a consequenca of):

INTESTINAL OBSTRUCTION Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last CASTRO INTESTINAL BLEEDING Due to (or es e consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? ARRHYTHMIA CARDIAC 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evallable prior to completion of cause of deeth? 24a. Was an autopsy SEPSIC 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/OutpetienI 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 110 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde

Examiner P.O. Box 68760, Division of Vital Records,

Physician

/Medical

Examiner

Director

Be

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours aftar death with the Manyian Depertment of Health and Mantle Hygiene.
Important: If time 27 is marked other than "natural; or itema 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner mantle moralised as

Physician

/Medical

Physician/Medical Examiner

Completed

Be

Certification: To

Medical

29a. Certifier

29b. Signature end title of cartifier

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the buriel-transit

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State Registrar

1 Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) and menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

BON SECOURS HOSPITAL

Cruzm.s 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

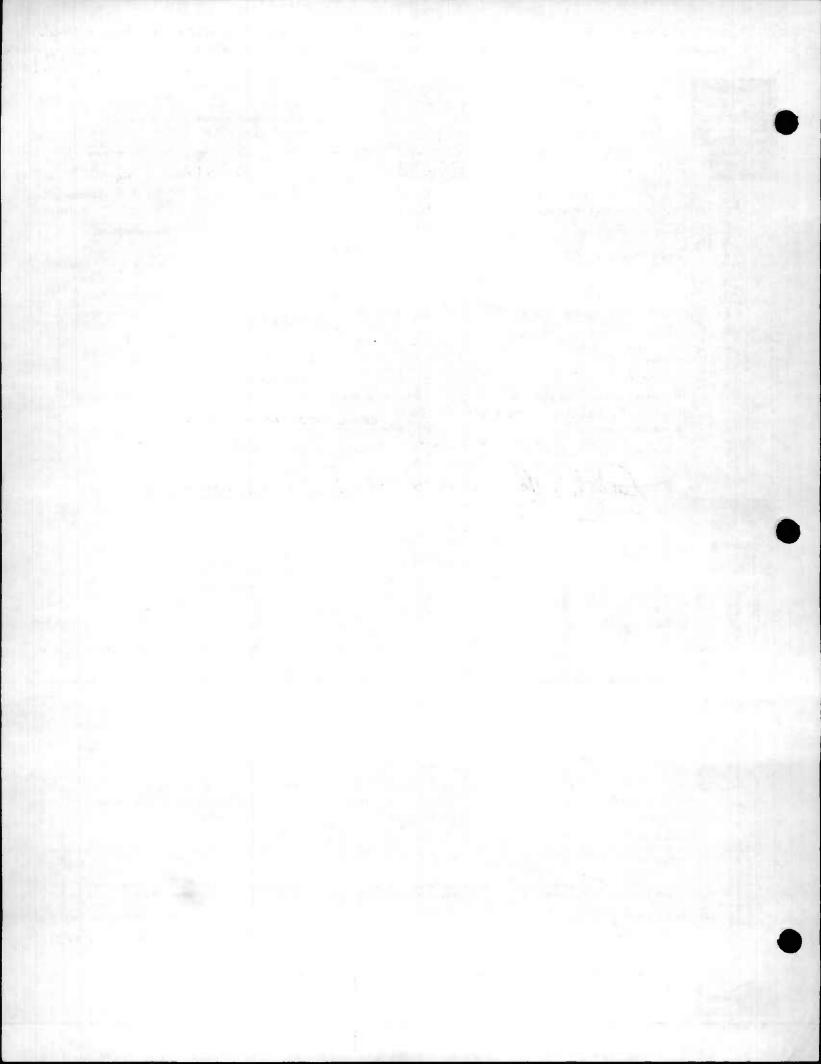
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CRUZ ROSITA M. S

MAY 1 9 2000

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Deeth Vear Richard 9:00AM Priller MAY 13 2000 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 312 Julias Lane Pasadena, Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) APR 7, 19 Birthpleca (State or Foreign Country) 7. Age (In yrs. last birthday) 1 ☑ M 2 □ F Days 216-16-2480 76 Yrs. 1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 Julias Lane 21122 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Merital Stetus 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Mechanic Glidden Paint 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Martin Priller Agnes Finback 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Evelyn Priller - wife 312 Julias Lane, Pasadena, Md. 21122 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 5/16/00 1) Burial 2 Cremetion 3 Removel from State Meadowridge Memorial Pk. 4 ☐ Donetion 5 ☐ Other (Specify) Elkridge, Md. 21. Signature of Funeral Service Licensee 22. Neme and Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. Molo50 7250 Washington Blvd., Elkridge, Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Carcinoma mota Hater Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed?

Physician /Medical Examine

Physician

/Medical

Examiner

Director

Funeral

Aq

Completed

Be

Funeral

Director

288-1

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If New 27 is merked other than "natural", or then any injury or other traumatic event. the Mantant

Saltimore, Maryland 21215-0020

8 8 # 23a

> for use as the burial-trans cate has been signed by page 2 should be detect p funeral director, 8

or Attending Physician: The law requires that the death certificate be executed

certificate

After this

Hospital 24 hours a Funeral D

P.O. Box 68760.

Records,

Division of Vitai

completely To the I within 2.

State Registrar

Physician/Medical Examiner Completed Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Naturat 5 Pending investigation hours after death. neral Director: Aft y filled in by the fur 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29b. Signature and this of certified 29c. License number

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No

26. Placa of Deeth (Check only one)

Location (Street end Number or Rural Route Number, City or Town, State)

1 Yes 2 No

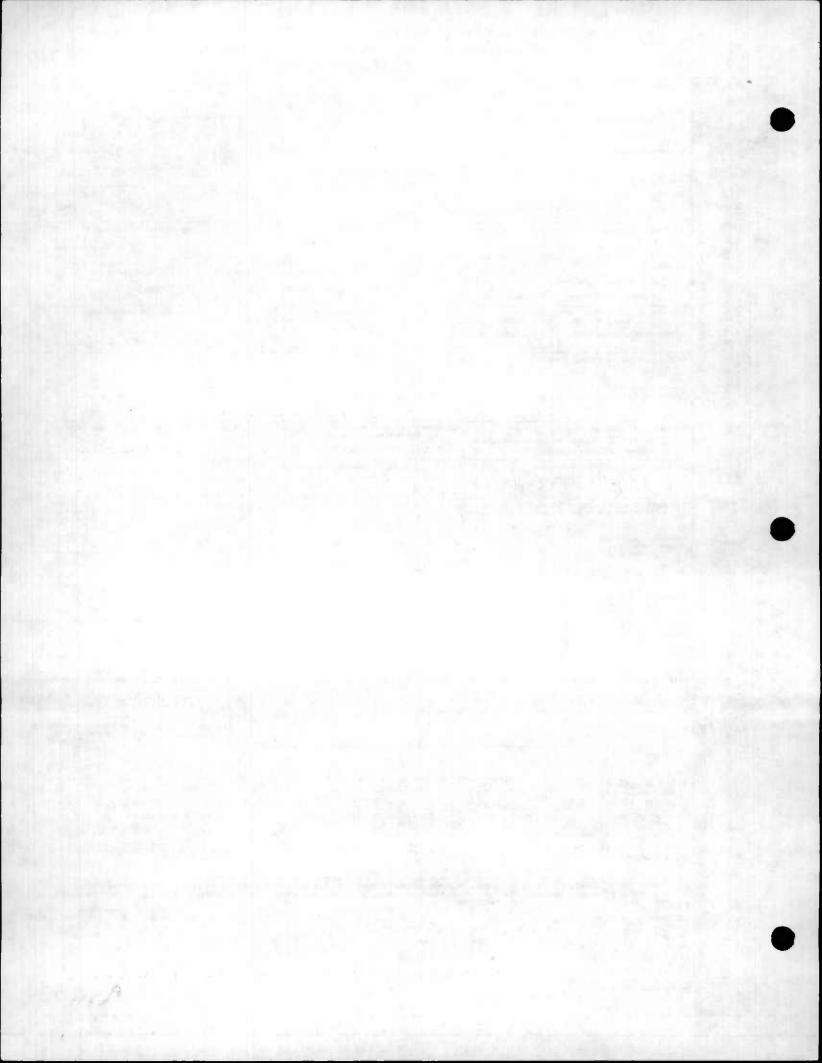
29d. Date signed (Month, Day, Year)

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Hosp Drive Glen Burnie, had 21061 SCHWADT 2 4-DAVID

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 6 2000

Ceely



amend item 23b per phys. G784 6/23/00 yg Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month **Physician** FRED F. PSIMER 7:40 am May 2000 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 18324 Derwood Drive, S.W. Rawlings Allegany If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthpieca (Stete or Foreign Country) **Funeral** Months Deys Hours 1 MM 2□ F Yrs Director 214-07-2468 86 Oct. 30,1913 West Virginia Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner naist be notified at Director 1 ☐ Yes 2 No MD **Allegany** Rawlings the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? With items 23a 18324 Derwood Drive, S.W. 21557 death Funeral USA 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yas or No-ff Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Raca - American Indian, Bteck, White, etc. Pages 1 end 2 should be filed within 72 hours effer onent of Health end Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or iter 1 ☐ Yas 2 X No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: 3 □ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Kaiser Refractories Dye Maker 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Benjamin Psimer Dora Young 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) Depertment of Health er Important: If item 27 is any injury or other trauonce. Norma J. Psimer/Wife 18324 Derwood Drive, S.W. Rawlings, MD 21557 Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from State May 5 4 ☐ Donetion 5 ☐ Other (Specify) The Cumberland Crematory 2000 Cumberland, MD 21. Signeture of Funeral Sarvica Licensee 22. Name end Address of Fecility Smith Funeral Home recen d 85 S. Main Street Keyser, WV 26726 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximete intervet Between Onset end Deeth **Physician** Metastatic Carcinoma /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner SCIPI or Attending Physician: The law requires that the death certificete be executed for use as the buriel-transit Sequentially list conditions, if eny, teeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Division of Vital Records, P.O. Box 68760 physiclan Physician/Medical Due to (or es a consequenca of) ate has been signed by the e page 2 should be detached Part fl. Othar eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? 1XXXes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveitable prior to completion of cause of daath? Completed 24e. Wes en eutopsy performed? certificate has 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this filled in by the funeral 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel Injury s efter deeth. 1 Tes 2 No 2 Accident 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 Sulcida 6 Could not ba determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours Certifying Phyeiclan: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 29a. Certifier Medical completely (Check only one) 2 Medical Examinar: On the basis of examination end/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Within 2 To the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) nou 30. Neme end eddress of person who completed cause of death (Item-23a) (Type, Print) 4 Mahesh B. Shroff, 390 Carskadon Lane M.D. Keyser, WV 26726 MAY 0 5 2000 32. Registrer's Signature State

DHMH 16 Rev 6/95

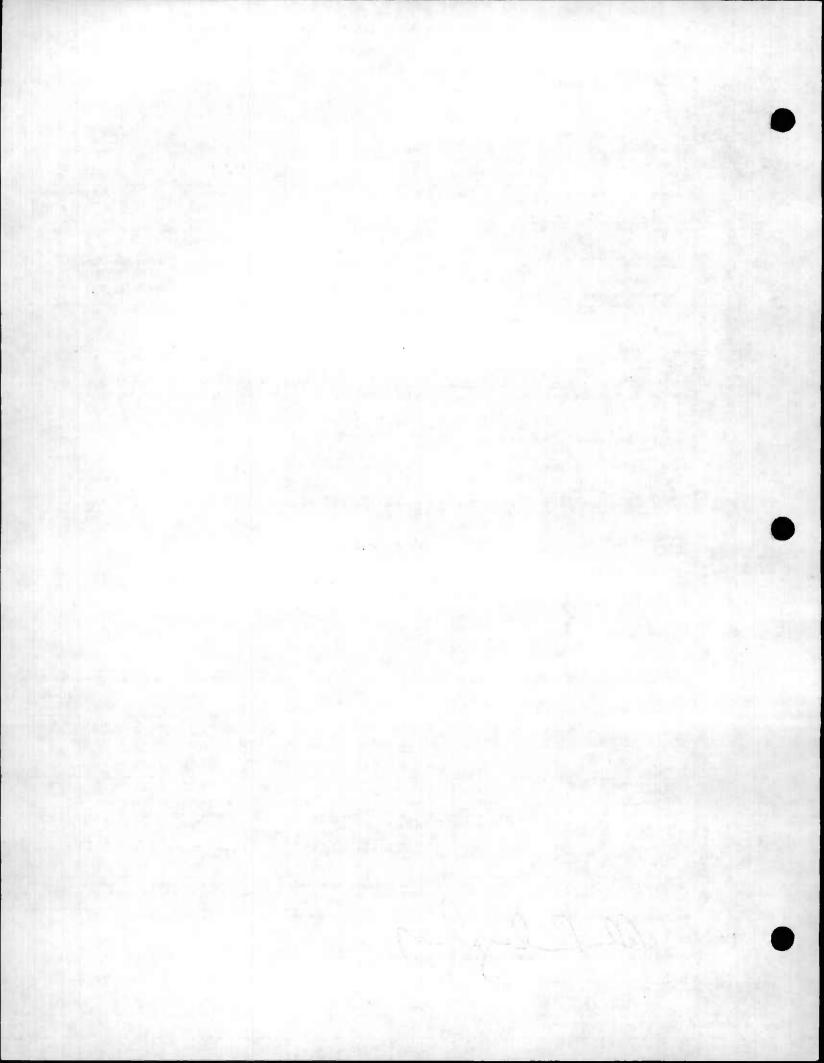
Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 17371

						ertificat				Reg. No.			
Physicia	Decedent's Nama (First, Middla, Last) Physician							2. Data of E Month	Day	Year 3. Tima of Death			
/Medic Examin	al	Theresa C. Padgett							May 15, 2000 8:35 4b. City, Town, or Location of Death 4c. County of Death				
		Holy Cross Hosp:	tal					Silver S	Spring	Montgo	mery		
Funeral Director		5. Social Security Number 578–28–2692	If Under 24 H Hours M	rs. 8. Data of E		9. Birthplace (Stata or Foreign Country) Virginia							
and anything set above tiled at		Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. In											
	to	Maryland Montgomery Wheaton											
vith the M t or 28e-f be notifie	Directo	10e. Street and Number				10f. Zig	Code			10g. Citizen of V	Vhat Country?		
Maryland 21215-0020 sid 2 should be liled within 72 hours after deal th and Mental Hygiene. 27 is merked other than "natural", or items t resummit event, the Medical Examination.	by Funeral	11. Marital Sfatus 1 Nevar Marriad 2 Marri Widowed 4 Divorced	12. Was Deceden Armed Forcas d 1 Yas 2 If Yas, Giva Yaar or Datas	?] No	I,S. 10			dispanic Origin? an, Mexican, Pu Specify:	(Specify Yas or ferto Rican, atc.)		e - American Indian, ck, Whita, etc. White		
S-O	Completed	15. Decedent		16a. Dec	edent's Usu	al Occu	pation	and in a	16b. Kind of Business/Industry				
E	춵	(Specify only highast grada completed) (Giva kind of work done during n [Blementary/Secondary (0-12) College (1-4or 5+) Iffa. DO NOT use retired)						d)	O WORKING				
Man and and and and and and and and and a	5	12			Book	keeper	•			Account	ing		
D atte	Bec	17. Fathar's Nama (First, Middla, L	ast) 18. Mot					18. Mother's N	ama (First, Middle, Maiden Sumama)				
/an Ment Ment Ment Ment Ment Ment Ment Men	0	Claude B. Ashwell	.1					Sicily	Ann Scr	iggs			
and and and and and and and and and and		19a. Informant's Name/Ralationsh	ip (Type, Print)		19b. Ma	iling Addres	(Street	t and Number or	Rural Routa Num	ber, City or Town,	Stata, Zip Code)		
and 2 south a n 27 is		Christopher A. I	adgett/ So	n	180	3 Fran	wa1	1 Ave.,	Wheaton	, MD 209	002		
e and		20a. Mathod of Disposition		20b. F	Place of Dis	position (Na	ma of		Data		City or Town, Stata		
Page Ment of ury or		1 XBurial 2 Cramation 4 Donation 5 Other (Sp	ecify)	8.	dar H	ill Ce	met	ery	5/19/0	Suitlar	nd, MD		
Ball permit Depart Import any try any try		21. Signature of Funaral Sarvice L SUB 23a. Part 1. Entar tha disaasa, or shock, or haart failura. List of		ed tha deat		Franci 500 Un	s J	rsity Bl	Lvd., W.	al Home, Silver S arrast,	Approximata Interval Between		
Physician We dit Examiner		23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on each line. Immediate Causa (Final disaasa or condition rasulting in death) Due to (or as a consequence of):											
7	<u>=</u>		- h Probab	le ca	rdiac	arrhy	thm	ia					
cute	Examiner	Sequentially list conditions,	5.			equence of)			08/6 3/8				
DS/DU, ifficate be exe g physician a as the burial-	۱۵	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Arteri	oscle	rotic	Cardi	ova	scular I)isease		1		
do / ou, tificate be executed go physician and as the burial-transit	edical	Cause (Disease or injury that initiated avants resulting in death) Last Dua to (or as a consequence of):											
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bed ab	Physician	Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause						ven in Part I.	n Part I. 23b. Did tobacco use contribute to				
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necords,	Completed	Insulin Dependent Diabetes Mellitus							24a. We	24b. Were autopsy findings available prior to completion of cause of death?			
The law ate has page 2	E								1	1 Yas 2 No 1 Yas Z			
delan: The certificate rector, pag		25. Was casa rafarred to medical						26 Place of I	Death (Check onl				
Physician: This certificat	e Be	examinar?	Hospital: 1 Alnpat	inet of	ER/Outpatient 3□ DOA			Other					
Attending Physical Colors or death. Sector: After this by the funeral d	atlon: To	27. Mannar of Death 14. Natural 5 Pending 2 Accidant Invastig	28a. Data of In (Month, D				28c. Inju	4 IVUISIN	1	oma 5 ☐ Rasidence 6 ☐ Othar (Specify, 28d. Describe how injury occurred			
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Sulcida 6 ☐ Could n 4 ☐ Homicida datarmi	y, office		28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)								
Hospi 24 hou Funer letaly fill	edical	29a. Cartifier XCertifying (Check only one) 2 Medicat E	1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causand manner stated.										
o thi	Me	29b. Signature and Nia of certifies 29d. Data signed (Mo											
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10		let x	Kan	al	w		52	261 May 15, 2000			2000		
		30. Nama and addrass of person v	/						20000				
			.299 Lamber			ilver	Spr	ing, MD	20902				
Stat Registra		31. Data filed (Month, Day, Year) MAY 17	2000 32. Regis	trar's Signi	atura A	1	De 10						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Daeth 3. Time of Death Dey MAY **Physician** 14, 2000 LINDBERGH PARKER 8:15PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner MARINER HEALTH AT CIRCLE MANOR KENSINGTON MONTGOMERY If Under 1 Year if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) OCT 8, 1931 9. Birthplace (State or Foreign Country)
N. CAROLINA 5. Sociel Security Number 7. Age (In yrs. last birthday) Funeral Months Hours 68 237-50-4586 Yrs Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at D.C. WASHINGTON 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1401 NEW JERSEY AVENUE N.W. 20001 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, tra Medical Examiner must Funeral . Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Black, White, etc. 1 Yes 2 No If Yas, Giva Yaar or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK ۵ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedant's Usuai Occupation (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) 8 TH College (1-4or 5+) DELIVERY MAN LINEN OF THE WEEK 18. Mother's Name (First, Middle, Maldan Surname) 17. Father's Name (First, Middla, Last) Be LAWRENCE PARKER RUTH CLARK 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) HATTIE L. PARKER (WIFE) 1401 NEW JERSEY AVE. N.W., WASH, DC. 20001 20b. Pleca of Disposition (Nama of cematary, crematory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Deurlai 2 □ Cremation 3 □ Removal from State FT. LINCOLN CEMETERY5/20/00 BLADENSBURG, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Num and Address of Figure ROYSTER FUNERAL HOME 3821 14TH ST. N.W. WASH, DC.20011 du 23a. Part1. Enter the disant story complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onsat and Death **Physician** NEUMONIA Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Examiner PATORY The law requires that the death certificate be executed burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence, and Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or as a consequence of) use as 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably Unknown been signed by should be detac þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy Completed page 2 No 1 ☐ Yes 1 ☐ Yes 2 No certificate Hospital or Attending Physicien: 25. Was case referred to medical examiner? director, 26. Place of Deeth (Chack only one) Be Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 6 | Other (Specify) 1 Yas 2 No 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Natural 5 Panding investigation 24 hours after death. 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) illed in by 4 Homicide

Cartifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) end menner stated.

29c. License number

29d. Dete signed (Month, Dey, Year)

State Registrar

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29a. Certifier (Check only

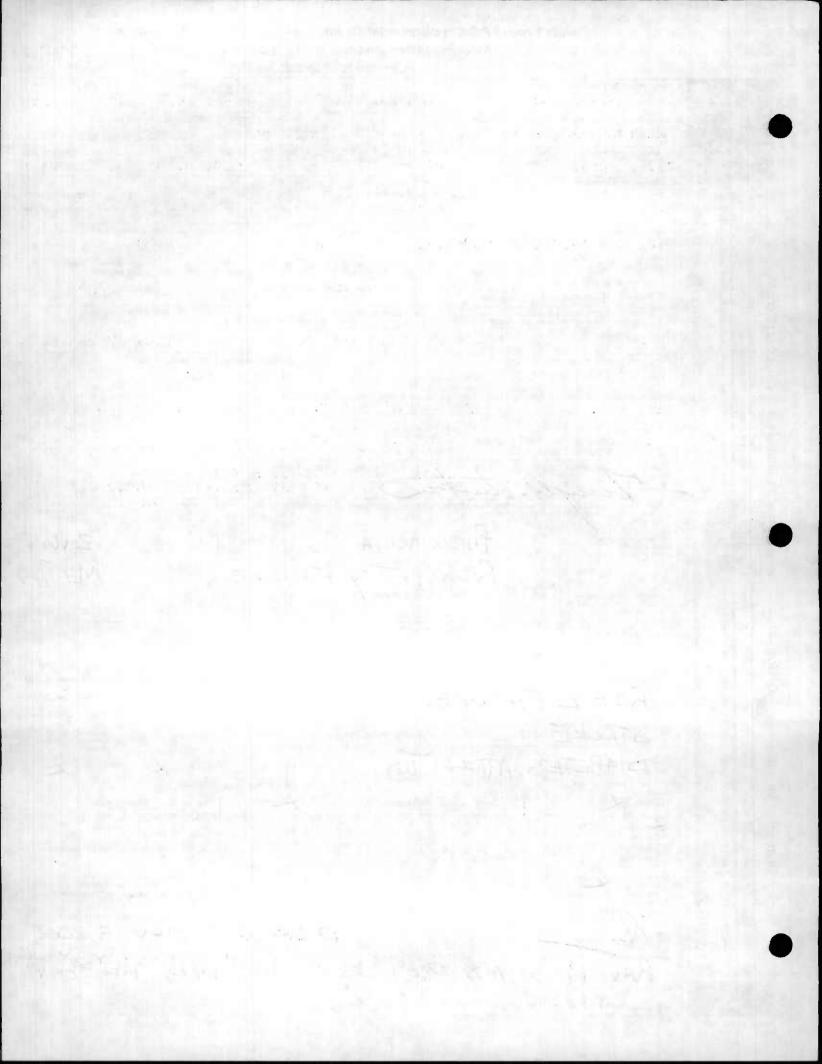
29b. Signatury and little of certifler

31. Date filed (Month, Dey, Year)

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drass of person who complated causa of death (Item 23a) (Type, Print)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Spratt Patrick Winnifred 2000 9:30 AM 11, May /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg 109 Twelve Oaks Drive Montgomery If Under 1 Year If Undar 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F Yrs. 66 Director 440-32-8302 Jan. 15, 1934 0klahoma Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or flems 23s or 28s-1 show any Injury or other traumetic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠Yes 2□No Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 109 Twelve Oaks Drive United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Giva Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamentary/Secondary (0-12) College (1-4or 5+) 4 Artist 18. Mothar's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be 2 Francis Joseph Spratt Fisher Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 12804 Talley Lane, Darnestown, Maryland 20878 Kathleen Kurkjian/Daughter 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park 5/15/00 Rockville, Maryland 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** fmmediate Cause (Final disease or condition resulting in deeth) /Medical a Chronic Obstructive Pulmonary Disease Years Examiner Due to (or es e consequence of) Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunist-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco usa contributa to the cause of death? 1⊠Yea 2□No 3 Probably 4 Unknown Lung Cancer, Pneumonectomy Records, à 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? 1□Yes 2HNo 1 ☐ Yes 2 ☐ No Division of Vital 26. Place of Deeth (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ₺ Residenca 6 ☐ Other (Specify) 1⊠ Yes 2□ No Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. fnjury at Work? 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 29a. Certifier edicai 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29b. Signatura and titla of 29c. License number 29d. Date signed (Month, Dey, Year) 15 LOW) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Md. 20850 Chanales, M.D. 15225 Shady Grove Road #205 Alan S.

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31. Date filed (Month, Dey, Year)

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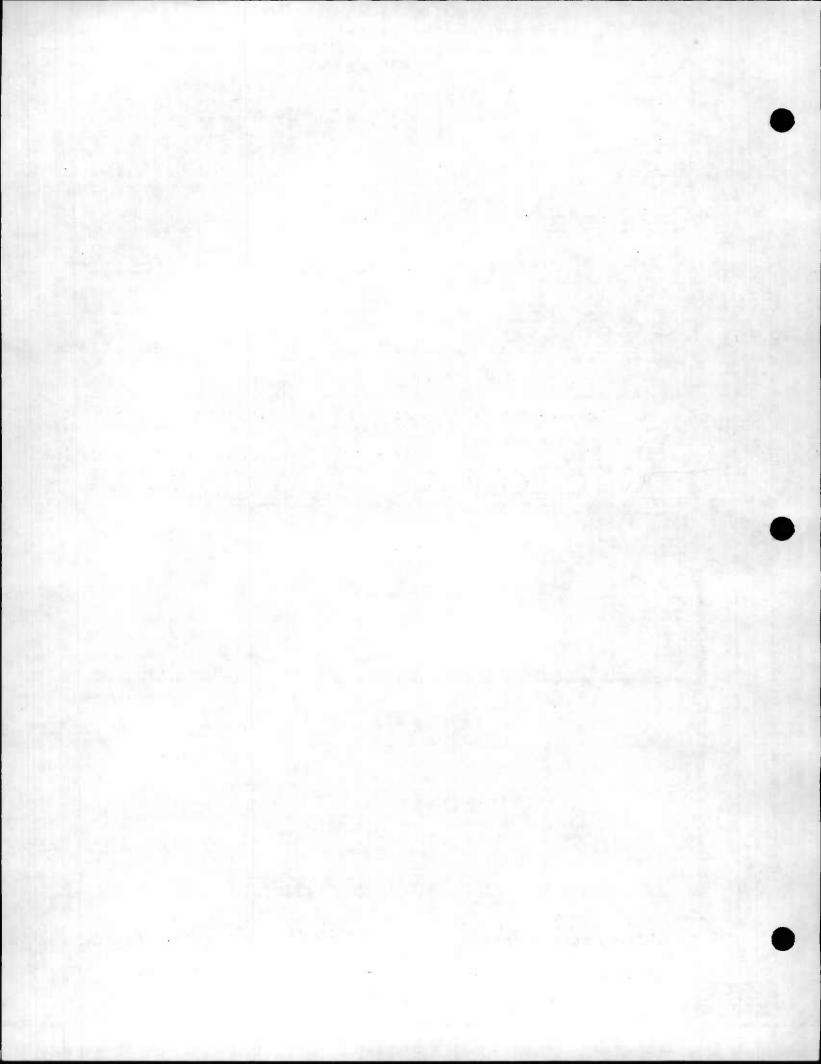
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32. Registrar's Signature

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Otata of Manufaud / Department of He	nolth and Mantal Hydiana O O

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Peters Dorothy Jean 9:20 am 13 $a \infty$ /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 77 Yrs. 8. Date of Birth (Month, Day, Year) Oct.26,1922 Mary Land 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 218-18-2331 1 □ M 2 TF Director Usual Residence of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmatic event, the Medical Examiner man be negliged. 10c. City, Town or Location
Baltimore 10b. County 10d. Inside City Limits Maryland N/A 1 X Yas 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21209 4669 Falls Road Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - Amarican Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Specify:White 1 Tes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) Printer Printing 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be Frank Russell Peters Jennie Jacobs P 19a. Informant's Name/Ralationship (Type, Print)

In19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, State, Zip Code)
Ruth J. Peters/Sister-Law 9825 44th Way North Pinellas Park, FL 33782 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Chesapeake Crematory 5/16/00 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr.Baltimore,MD 21286 21. Signature of Funeral Service Ligenseu 23a. Partf. Enter the disaase, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS two hours disease or condition resulting in death) **Examiner** Dua to (or as a consequenca of): Physician/Medical Examiner ASPIRATION PNEUMONIA attanding physician and I for use as the bunal-transit The law requiras that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Last Due to (or as a consequanca of) Effect Stroke Division of Vital Records, P.O. Box 68760, ato Due to (or as a consequence of) been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ponknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed s certificate has I director, page 2 s 2 PNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

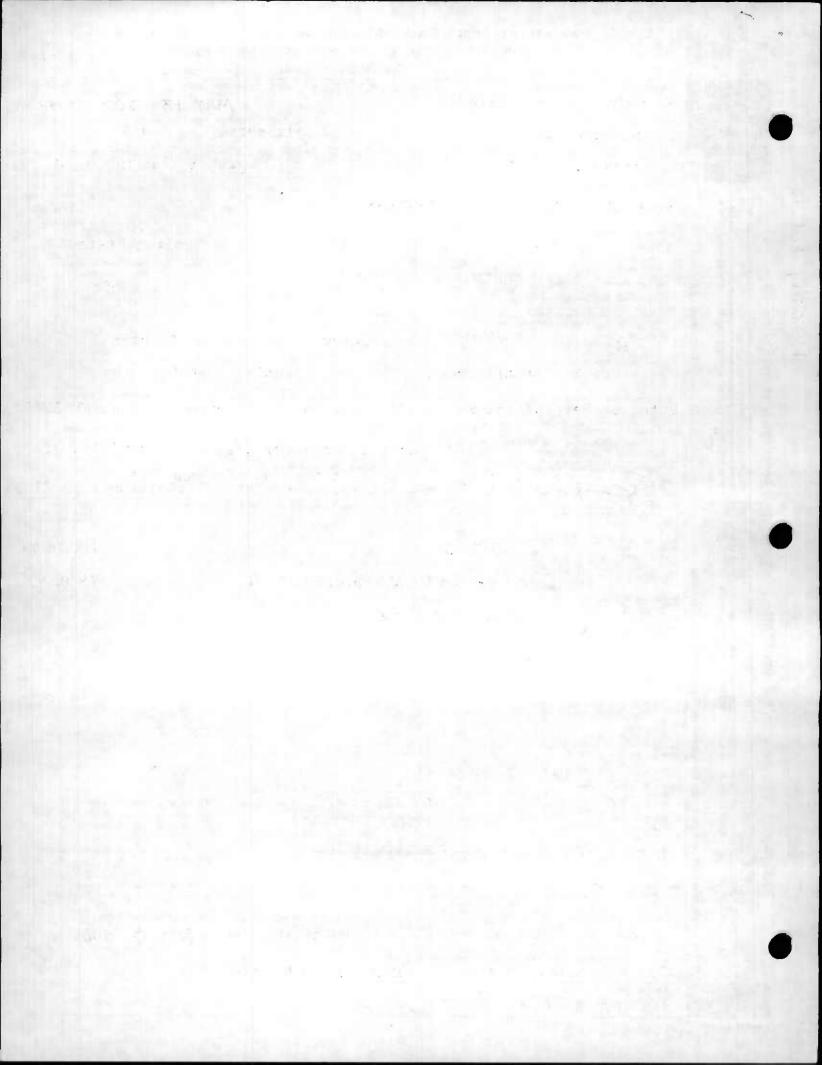
To the Funeral Director: After this certifica completaly filled in by the funeral director, p Be 25. Was case raferred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Watural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 Sulcide 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29d. Date signed (Month, Day, Year) 29c. Licensa number 29b. Signature and title of certifier May 14, 2000 Geerce H45931 1 Beborah U 30. Name and address of person who completed cause of daath (Item 23a) (Type, Print) Deborah Pierce M.D. 7220 Park Heights Avenue Baltmore MD Zizos. D. Park Heights Avenue

State Registrar 31. Date filed (*Month, Day, Year*) MAY 1 6 2000

32. Registrar's Signature

4. Sparks



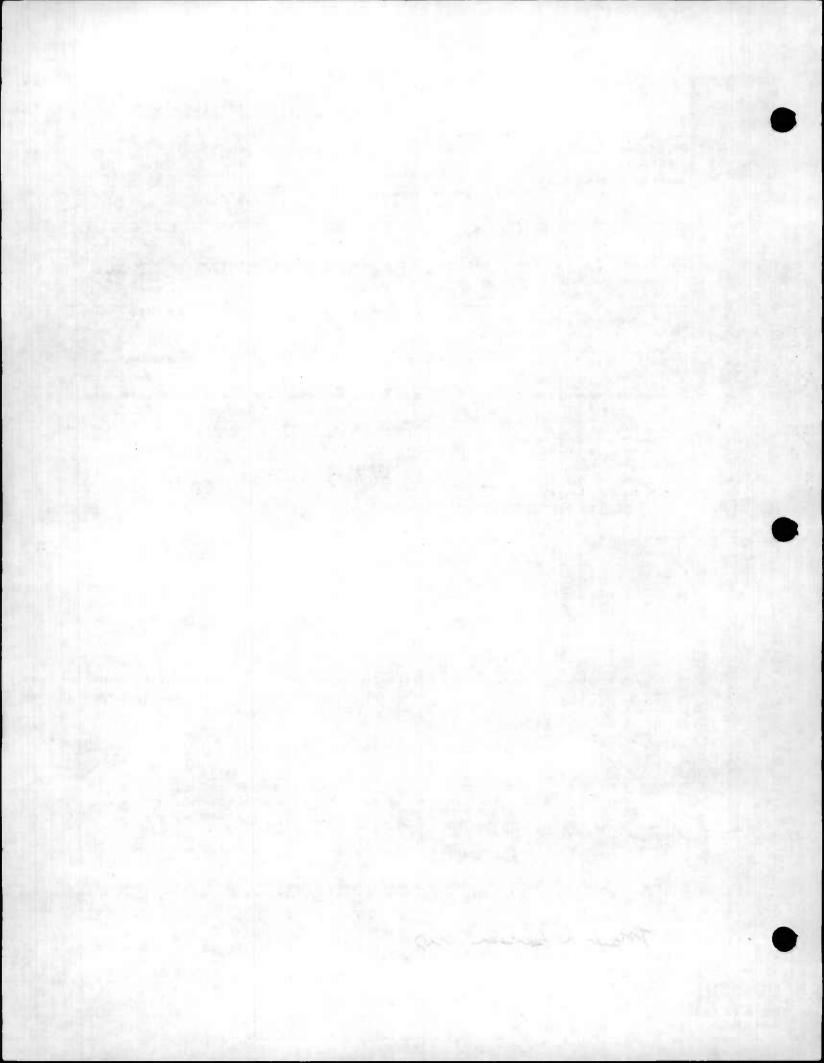
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Yaar **Physician** William Rometsch Pruitt MAY 11, 2000 6:10 AM /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Undar 24 Hrs. Hours Min. 6. Sex. 1 M 2 F If Under 1 Yaar 8. Data of Birth (Month, Day, Year) August 1, 1923 7. Age (In yrs. last birthday) Birthplaca (State or Foreign China) 5. Social Security Number **Funeral** Days 189-16-3622 Yrs. Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show other traumatic avant, the Medical Examinar must be notified at MD Cecil 1 ☐ Yas 2 No Director Conwingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or flarm 23a or 2 any injury or other traumatic avant, the Medical Examinar must be apple. 781 21918 Ragan Rd United States Funerai Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - American Indien, Black, Whita, atc. 11. Merital Stetus 1 Nevar Married 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: à 3 □ Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Doctor 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Robert Pruitt Evelina Rometsch 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Pruitt / son 25 Upper Hook Rd Rhinebeck, NY 12572 20e. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from Stata Chesapeake Crematory Inc 5/13/00 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility CAFA Stephen D. Lohmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286 21. Signature of Funeral Service Licensas Hardesty ama 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onsat and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical MALNUTRITION 2 MONTHS Examiner Dua to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disease or injury that initiated evants rasulting in daath) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown SCHIZOPHRENIA þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? DEPRESSION completion of cause of death? page 2 : 1 Yas 2 No 1 Yas 2 No director, 8 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Chack only one) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding invastigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datermined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homloida 29a. Certifiar Medicai 1 🔯 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) D. Heusen 3+ D48215 MAY 11, 2000 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) MARK HEUSER, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 31. Data filed (Month, Day, Year) 32. Megistrar's Signatura 1 6 2000 State MAY Registrar

DHMH 16 Rev 6/95

NAME KNOWN TO PHYSICIAN WILLIAM ROMETSCH PRUITT



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** SARA MARR ROSSING MAY 13 2000 12:10AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Daath Examiner 202 RAILROAD AVENUE EAST NEW MARKET DORCHESTER If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) 9. Birthplaca (Stata or Foreign **Funeral** 1□M 2 F Months Days Hours 71 213-24-2059 MARYLAND Director DEC. 19, 1928 Usual Residence of Decedant 10b. County 10c. City. Town or Location I be filed within 72 hours after death with the Marylar ntal Hygiene. ed other than "natural", or items 23e or 28e-f show e other than "natural", or items 12e notified at 10d. Insida City Limits 1 X Yas 2 No Director MARYLAND DORCHESTER EAST NEW MARKET 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 202 RAILROAD AVENUE 21631 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, White, atc. Baltimore, Maryland 21215-0020 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 🖸 No Specify: Specify: ð 3 X Widowad 4 ☐ Divorced WHITE Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) MEDICAL SECRETARY permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If then 27 is methed other any injury or other traumatic avens 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be THOMAS HAMILL SMITH, SR. SARAH ELIZABETH CORKRAN 2 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) SARAH E. SMITH/MOTHER P.O. BOX 176, EAST NEW MARKET, MD 21631 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data Burial 2 Cremetion 3 Removel from State 4 Donation -5 ☐ Other (Specify) EAST NEW MARKET CEMETERY 5/16/00 EAST NEW MARKET, MD eral Service Lic 22. Nama and Addrass of Facility ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631 Inter the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart feilure. List only one cause on each line. Approximata Intervel Between Onsat and Daath **Physician** months Immadiata Causa (Finel disaasa or condition resulting in daath) /Medical Nuck carcinona Examiner Dua to (or as a consequance of): Examiner attending physician and for use as the burial-transit The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical that initiated avants Dua to (or as a consequence of): rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of causa Completed 24a. Was an autopsy peen certificate hes 1 ☐ Yas 2 No 1 □ Yas 2 □ No Division of Vital Hospital or Attending Physician: Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) s efter death.

I Director: After this cond in by the funeral director. ဥ 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Day Year) Certification: 28b. Tima of 28d. Describe how Injury occurred 5 Panding Invastigation 1. Natural 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Streat end Number or Rurel Routa Number, City or Town, Stata) Place of Injury - At homa, farm, straet, factory, office building, atc. (Spacify) 4 T Homicida To the Hospital o within 24 hours eff To the Funeral DI completely filled in Certifying Physicien: To the best of my knowledge, deeth occurred et the tima, date and place, and due to tha ceuse(s) end manner as stated.

| Madical Exeminer: On the basis of axemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. Medical 29a. Certifier 29d, Data signad (Month, Dav. Year) 29b. Signature and title of 29c. Licansa number 00 ma and addrass of person who complated causa of death (Item 23a) (Type, Print) 30. M faston

State Registrar

31. Data filed (Month, Day, Year)

32. Registrar's Signatura

1 6 2000

100 S A T FAST

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 15 **Physician** STARLEY RUDOLPH, JR. RAYMOND 2000 May 1:28 PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min June 29, 5. Sociel Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. last birthday) Birthplace (Steta or Foraign Country) **Funeral** Yrs. 1938 Washington DC **Director** 579-46-8960 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Newburg Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò tam 27 is marked other than "natural", or items 23s or other traumstic avant, the Medical Examiner must be 13556 Simms Lane 20664 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ DNo If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural; or item any injury or other traumatic avant, the materials." 1 Nevar Merried Merried Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Printer Printing 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Raymond Starley Rudolph, Sr. Margaret Mangum Ivy 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 13556 Simms Lane Newburg, MD 20664 Joan Rudolph/Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Resurrection Cemetery5/19/00 Clinton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensea AREHART-ECHOLS FUNERAL HOME, P.A. M00945 chul P.O. BOX 567 LA PLATA, MD. 20646 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth Physician Immediate Cause (Final diseese or condition resulting in death) /Medical SEPTIC SHOCK **Examiner** Physician/Medical Examiner PHRITONITIS or Attending Physician: The law requires that the death certificate be asscuted Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that leited as each for use as the burial-trar VAI FAILURE Division of Vital Records, P.O. Box 68760, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown DINGBSONIOL py Be Completed 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? ENDERC CARDIDIARIN completion of cause of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate STATUS POST funeral director, 25. Wes casa referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Nonpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 20 No this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Aftar 1 Netural 2 Accident 5 Pending Hospital or Attending 24 hours after death.
 Funeral Director: After 1 Yes 2 No Investigation filled in by the 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 15. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifler completely (Check only one) To the I 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Negre end address of person who complated causa of death (Item 23a) (Type, Print) 12070 Old Line Center Waldock, MD2402

Registrar **DHMH 16 Rev 6/95**

State

32. Registrer's Signeture

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Please Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O 2784 6-8-00 WR. Reg. No. 00-2632-037 Robert Rowley III AMEND ITEMS: #23 PART I, 27, JVW 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth Month Day **Physician** May 10,2000 Robert Puttman Rowley, III
4e Facility Name (If not institution, give street and number) 02:42 A.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Leonaeu Lowiz

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)

Time 10, 1965 Saint Mary's Hospital Saint Mary's 6. Sex 1 € M 2 □ F 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Yrs. Maryland Director 262-96-7049 34 Usual Residence of Deceden the Maryland il Hygiene. other than "natural", or itema 23a or 28a-f show vent, the Medical Examiner must be nothing at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Directo Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 27155 Cox Drive 20659 U. S. Α. death Funeral Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Disabled Disability altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Pages 1 and 2 should be nent of Health end Mental If item 27 is marked or other traumatic ev Robert Puttman Rowley, Jr. Arlene Patricia Hunter 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert P. Rowley, Jr. / Father 27155 Cox Drive Mechanicsville, Maryland 20659 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Magate 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or page. Charles Memorial Gardens 13,2000 Leonardtown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature Turbral Septice Ligen 22. Name and Address of Facility M00052 Brinsfield-Echols Funeral Home, P.A. in Edward Brinsffeld, Ň. Jr. 30195 Three Notch Road Charlotte Hall MD 20622 23e. Part1. Enter the disease, or complication in et caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel METHADONE INTOXICATION disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examine ician end bunal-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760 Physician/Medical that Initiated events resulting In death) Last the Due to (or as a consequenca of): 98 esn P.O. Part It. Other stgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the causs of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by The law requires 24b. Were eutopsy tindings eveilable prior to completion of cause of death? 24a. Was en eutopsy performed? Completed has page 2 Yes 1 ☐ Yes 2 ☐ No of Vital Physician: 86 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 No 2 No this 28b. Time of A 28a. Date of Injury FOUND' Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Division FOUND: M 1 Natural 5 Pending Investigation 1 ☐ Yes 2 X No death. UNKNOWN 5-10-00 2 Accident 2:00 Director: / 6 X Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) after 4 | Homicide UNKNOWN UNKNOWN To the Hospital
within 24 hours a
To the Funeral C
completely filled Hospital edicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

**EXPMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier cumile munell O.C.M.E. May 10,2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

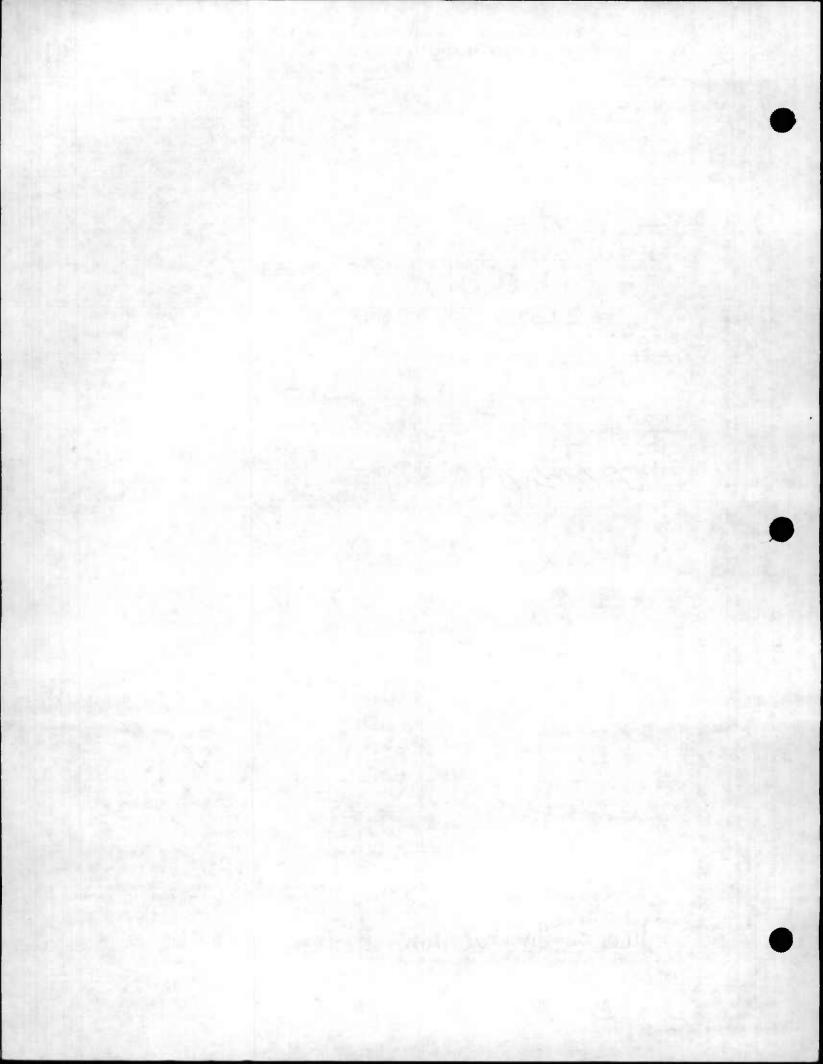
State

Registrar

31. Dete filed (Month, Day, Year)

MAY 17 2000

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 14 **Physician** 2000 May 2:33 AM Emmet Radcliff /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery 8 Date of Birth (Month, Dey, Year) Jan. 1, 1919 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 11 M 2□ F Yrs. Missouri 337-12-3373 81 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 20902 USA 11703 Lytle Street death Funeral 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 72 hours after 1 ⊠ Yes 2 □ No If Yes, Give 1 ☐ Never Merried 2区 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7: Hygiene. other than "nu College (1-4or 5+) Elementary/Secondary (0-12) Federal Government 12 5+ Cryptologist other 18. Mother's Name (First, Middle, Meiden Surneme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked othwent Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Ernest Radcliff Caroline Kemme 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 11703 Lytle Street, Silver Spring, Maryland 20902 Barbara Radcliff / Wife 20b. Place of Disposition (Neme of 20c. Location - City or Town, State Date 20a. Method of Disposition cametery, cremetory or other plece) 1 ☐ Burlal 2 ☑ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 05/17/00 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mame and Address of Fecility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service License 11800 New Hampshire Avenue of. 20904 Silver Spring, Maryland 23a. Part 1. Enter the disease, or composition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Cardiac arrest disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine Cardiac arrhythmia physician and s the bunal-transit Sequentially fist conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Arteriosclerotic cardiovascular disease Box 68760 certificate be Physician/Medical Due to (or es a consequence of): esn jo P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? eu signed by 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Non insulin dependent diabetes mellitus by Division of Vital Records. 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? The law page 2 s certificate has 1 Tes 21 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 □ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 ☐ Yes 2 X No After this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 (XNatural 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident Director: / 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by the 28e. Pleca of fnjury - Af home, farm, street, factory, offica building, etc. (Specify) 4 Homlcide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and dua to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier Medical

2

State

Registrar

31. Date filed (Month, Dey, Year)

30. Name and address of person who complet Alan R. Segal, M.D.

29b. Signature and the of certified

32. Registrar's Signature 2000

ed Cause of Geath (Item 23e) (Type, Frint)
1299 Lamberton Drive, Silver Spring, Maryland

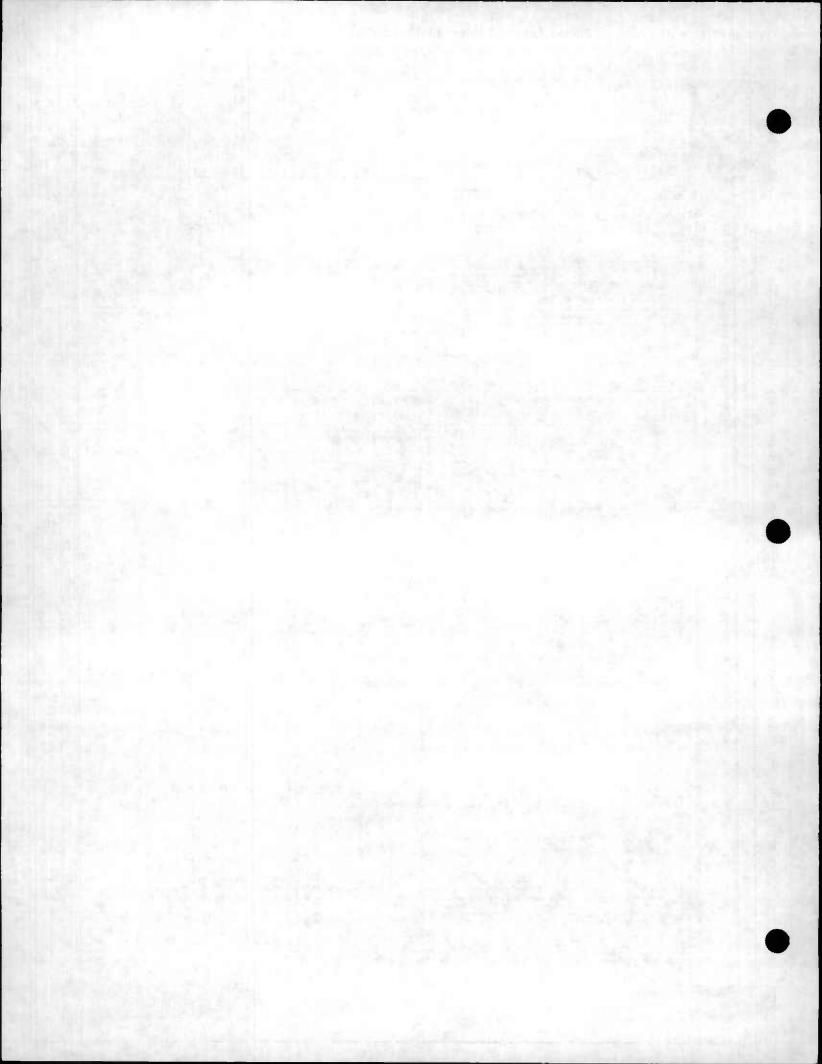
29c. License number

D52261

29d. Date signed (Month, Dey, Year)

May 15, 2000

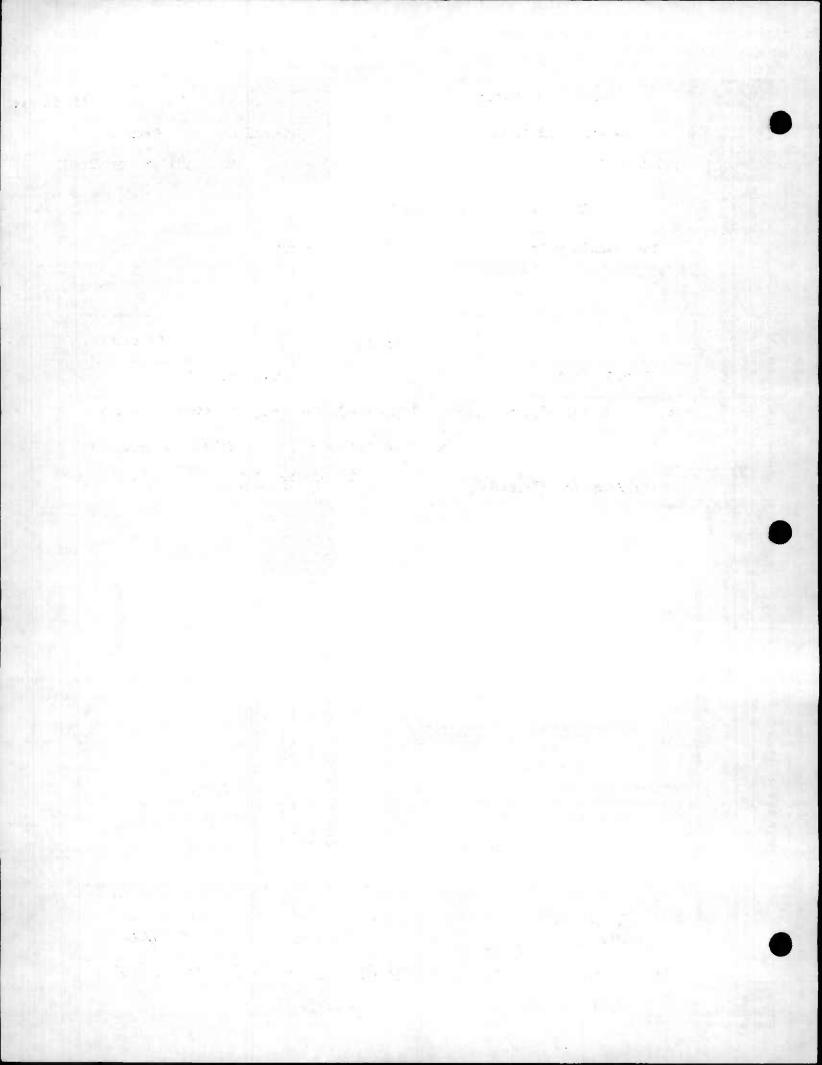
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

						Certific	cate of	Death		Reg. N	lo.]	7383		
	Physic	ian	1. Decedent'a Neme (First, Middle, L Virginia					Date of Death Month 1 Day 2000			3. Time of Death				
	/Medi Exami	cal	4a. Facility Name (If not institution, gi	Ridgely				4b. City, Tow	n, or Location of	_	c. County		4.30 AM		
	LAGIIII	ici	Golden Age Guest Home Sykesville Carrol										_		
	Funeral Director				e (In yrs. last b 94	94 Yrs. Months Deys Hours Min. 8. Dete of Birth Months Deys Hours Min. 000000000000000000000000000000000000							9. Birthplace (State or Foreign Maryland		
	e Maryland 3a-f ehow ruffed at	Director	10a. State 10b. County MD Ca rro	oll	10c. City, Tov Syl	wn or Location Kesvil						1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	th with th		10e. Street and Number 1442 Buckhorn	Road	10	f. Zip Code	21784		10g. (10g. Citizen of What Country? USA					
020	be filed within 72 hours aftar death with the Maryland tal Hygiene. d other than "naturat", or items 23a or 28a-f show event, the Madical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If If Yes, Give Yeer or Dates:			Decedent of h specify Cub es 2 No		n? (Specify Yes Puerto Rican, etc	or No- c.)		k, White,	can Indlen, etc. iite		
Maryland 21215-0020	J within 72 ho jiene. r than "natur	Completed	15. Decedent's E (Specify only highest gi	lucation de completed) College (1-4or 5+)			of work done OT use retire	petion during most of d)	of working	ing		Business/Industry			
d 21	offled withing the Hygiene.		11 17. Father's Name (First, Middle, Las	t)		Bookkeeper			a Nama /First #4	Cleric			Cal		
lan		To Be	John W. Hebb	,					ice Warf		ar Suman	9)			
, Mary	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship Mr. John T. Ridge						or Rural Route A				Code)		
altimore,	permit. Pagas 1 ar Department of Has Important: If Item: any injury or othe once.		20a. Method of Disposition 1 XBurial 2 Cremetion 3 Call Control Con		cemete	of Disposition ery, cremator, STOVE (y or other pla		5/18/2		Location - lenwo				
Balt	permit. Departr Importa		21. Signature of Funeral Service Licansee Paramod. Haylot 22. Neme and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, F Sykesville, MD 21784 (410)-795-												
			23a. Pert1. Enter the disease, or conshock, or heart feilure. List only	plicetions that caused	the deeth. Do						755-1	400	Approximete Intervel Between		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) e.										Onaet end Death		
	Examiner												10 days		
	bed sit	Examiner		b								1			
o`	axecu in and rial-trar	Ехаг	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying												
68760,	aath certificata be axecuted attending physician and for usa as tha bunal-transit	Medical	Ceuse (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of):												
×	nding l	n/Me	d									i			
). Bo	death he atter ed for u	Physician/	Part II. Other eignificant conditions	contributing to death bu	ut not resulting	in the underly	ring cause giv	ven in Pert I.	23b.	Did tobacc	tobacco use contribute to the cause of de				
P.0	that the death coned by the attended for us									1 Yee 2 No 3 Probably					
Vital Records,	requires been sign should be	Completed by								Was an aut performed?		ev	ere autopsy findings eileble prior to mpletion of cause death?		
- R	0 - 0	Com								1 ☐ Yes	2) No		Yes 2□ No		
Vita	yalcian: The scentificata director, par	Be	25. Was case referred to medical examiner?	11			0		of Deeth (Check	only one)					
5	Phys this aldi	7	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatle			DOA Oth	4 DV Nurs	ing Home 5				(y)		
	Attending I death.	Certification:	1 Neturel 5 Pending 2 Accident investigation	(Month, Day	28a. Dete of Injury (Month, Day Year) 28b. Time of linjury 28c. injury at Work? 1 Yes 2 No					28d. Describe how injury occurred					
DivIsion	l or Attendations after death Director:	ertific	3 Sulcide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exa	nysician: To the best of minar: On the basis of end manner sta	examinetion as	e, deeth occu nd/or investiga	irred et the tii ation, in my c	me, dete end opinion, death	place, end due to occurred at the t	the ceuse(s) end me nd place, (nner as s and due to	teted. o the cause(s)		
	To the Ho within 24 i To the Fu complatel	W	29b. Signature and title of eerifier				29c. Licens	e number f06		290.0	ste signes	(Month,	Day, Year)		
			30. Name and address of person who	completed cause of de	eeth (Item 23a)	(Type, Print)	20 1	5/Nor	BURG M	uD	217	24			
	Sta	ite	31. Date filed (Month, Day, Year)	. 7.	LIS (X)	1		LOOKS!	DUR 6		-110	/			
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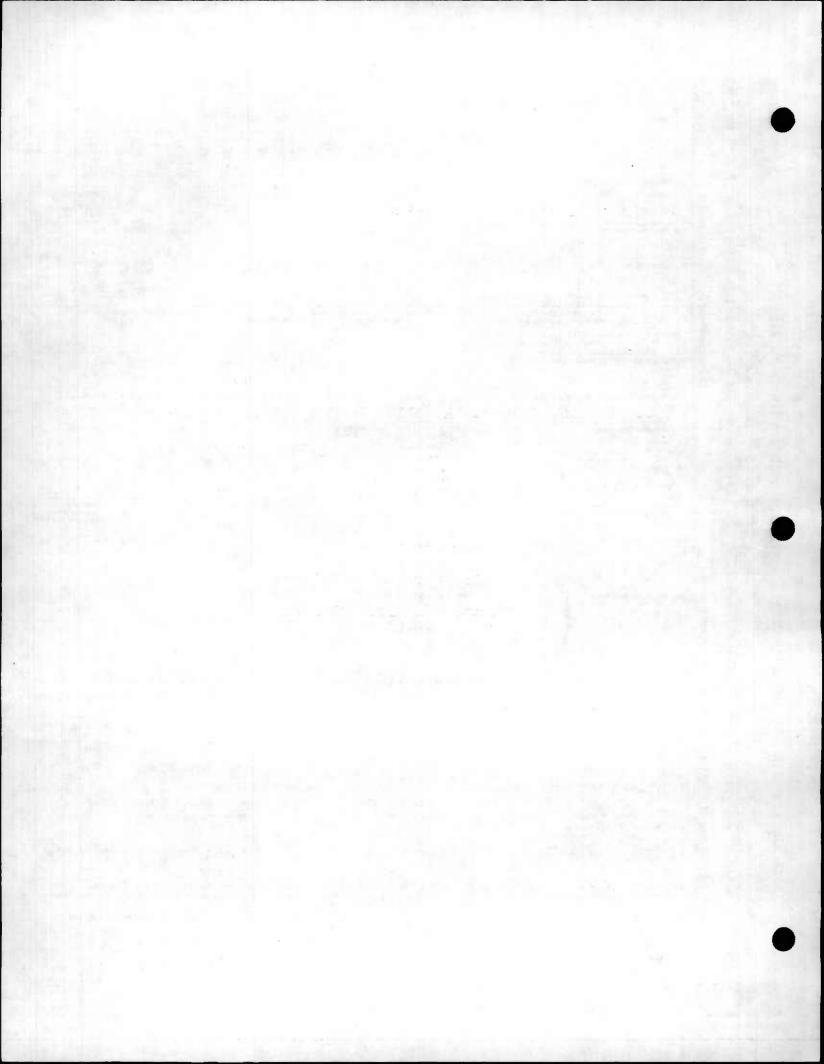
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10, 2000 MAY BEULAH Μ. RANDOLPH 5:15 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 7. Age (In yrs. last birthday) | If Under | Months | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1□M 250 F 84 Yrs. Director 722-05-5297 Usual Residence of Decedent Febl6,1916 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N☐Yes 2☐No Director MD Montgomery Dickerson 28a-f 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 20460 Beallsville Road 238 U.S.A. 20842 Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married 1 Yes 2 No If Yes, Give Yeer or Dates: 3altimore, Maryland 21215-0020 b 1 Yes 2 No Specify: Black Specify: ģ 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) Coilege (1-4or 5+) 12th Housewife Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If item 27 is manked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dennis Owens 2 Mozelle Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Wilkins (Daughter) 2115 Big Woods Rd., Dickerson, MD 20842 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 28 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 5/16/00 Mt Zion Cemetery Dickerson, MD Mature of Funeral Service Ligense 22. Name and Address of Facilit SNOWDEN FUNERAL HOME, P.A. Louxe ROCKVILLE, MD 20850 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 12 hours Pulmonary Edema Examiner Due to (or as a consequance of): Examiner 12 hours Left Ventricular Failure The law requires that the death certificate be executed ician and burial-trans Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): physician s the burie P.O. Box 68760. Coronary Artery Disease years Physician/Medical Due to (or as a consequence of): 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus signed be del Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a, Was an autopsy performed? page 2 1 ☐ Yes XX No 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No Aftar this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 TYes 2 □ No investigetion 2 Accident 24 hours after deat Funeral Director: 6 Could not be daterminad 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier To the Hosp within 24 hor To the Fune complately fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 30. Name end address of person who completed cause of death (item 23a) (Type, Print) 20837 19710 Fisher Ave., Poolesville, (MM Leonard Sax, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

MAY 15 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.0 1.700 5

hysician	1. Decedent's No	ame (First, Middle, L	ast)					2. Date of D		V	3. Time of Deeth		
(B.B Blanch	CA	ROLINE H	OUSTON RA	ANDOLPH	I			Month May 1	3, 2000	Year	9:10PM		
/Medical xaminer	4a Facility Name	(If not institution, g	ive street and number)		1	lb. City, Town, o	or Location of Dea		of Death			
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ineral	5. Social Security		Sex 7. A	ge (In yrs. las		er 1 Year s Days	If Under 24 H	rs. 8. Date of Bi	rth	9. Birth	place (State or Fore		
ector	577-03-		1□M 2NF	93	3 Yrs. Months	S Days	Hours M	Feb 06	1907	Vir	rginia		
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to to	MD	Montgom	nerv	Ken	sington						1 X Yes 2 □		
be notified Director	10e. Street and I					ip Code			10g. Citizen of W	Vhat Cour	ntry?		
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iner must	11. Marital Statu		12. Was Deceden	t Ever in U.S.	13. Was Dec	edent of H	lispanic Origin?	(Specify Yes or Nerto Rican, etc.)	0- 14. Race	e - Americ	can Indian,		
AB III	1 Never Ma	arried 2 Married	Armed Forces 1 Yes 2 1			ecify Cuba 200 No	Specify:	erto Rican, etc.)	Specify Specify	k, White,	etc.		
Exa.	3 N Widowed	d 4 Divorced	Year or Dates:	Year or Dates:					Ороспу	Whi	White		
dica dica	(Sc	15. Decedent's E pecify only highest g	Education rade completed)	1	16a. Decedent's Us (Give kind of w	ual Occup	ation during most of w	vorking	16b. Kind of Bu	siness/In	dustry		
나 다		econdary (0-12)	College (1-4or	5+)	life. DO NOT	use retired	1)						
4, the Medical	12				Homemak	er			Own Ho				
Be (ne (First, Middle, Las	st)				18. Mother's N	lame (First, Middle	, Maiden Sumam	e) Unl	cnown		
To B	Ash1e	y Jones											
	19a. Informant's	Name/Relationship	(Type, Print)		19b. Mailing Addre	ss (Street	and Number or	Aural Aoute Numi	per, City or Town,	State, Zip	Code)		
4.4	Carole	M. Randol	Lph (Day	ughter)	5979 Va	leria	n Lane	Rockvil	1e, MD 2	0852			
6	20a. Method of D	Disposition	*	20b. Plac	a of Disposition (N	ame of		Date	20c. Location -	City or To	own, State		
A Sent	1 Burial	2 Cremation 3 In 5 Other (Spec	☐Removal from State	9	e of Heav			5-17	Silver	SPri	ng, MD		
100		Funerat Service Lice	**	Jul	_		ss of Facility	1			0,		
A A A	144	Tunolar Corvos Ela	-					SONS, INC					
	20	apper	·				nsin Av		Washingt	on,	DC 20016		
	23a. Part1. Ente shock, or h	or the discusse or cor	mplications that cause y one cause on each	ed the death. I	Do not enter the me	ode of dyir	ng, such as card	iac or respiratory	arrest,		Approximate Intervat Between		
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niner	resulting in deat	h)	a. 1106.		esulting in death)								
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sician and burlai-transit cal Examir	Sequentially list if any, leading to ceuse. Enter Ur Cause (Disease that initiated eve	conditions, immediate iderlying or injury nits	bwith	Due to (or as	stive Hea	rt Fa	ilure			1			
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Nedical Certification: To Be Completed by Physician Medical Certification: To Be Completed by Physician Medical Certification: To Be Completed by Physician/Medical	Part II. Other sig 25. Was case re examiner? 1 Yes Z 27. Manner of Dr. 1 Netural 2 Acciden 3 Suicide 4 Homicid 29a. Certifier (Check only only only only only only only only	ferred to medical No sath S Pending investigative determined 1 Certifying P 2 Medical Exa	Hospital: Hospital: I Inpet	Due to (or as Du	stive Heass a consequence of sa ooa Othoo Ot	26. Place of Elections at the control of the contro	24a. Wa period 24a. W	Yes 2 No an autopay ormed? Yes 2 No one) iidence 6 Oth how injury occur (Street and Numb awn, State) cause(s) and ma date and piece, a 29d. Date signed May 13	24b. We occord of 11 occord of 11 occord of 12 occord occo	death? West 2 No Type 1 No No No No No No No No No No No No No			

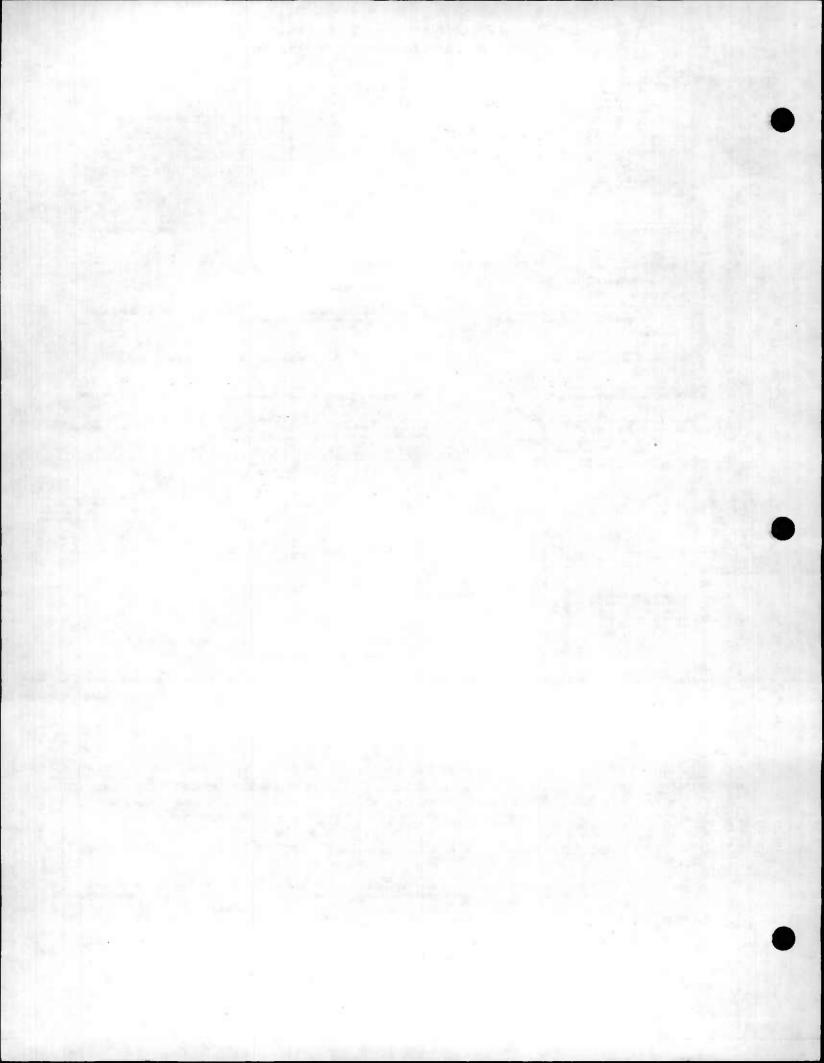


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Rizkalla **Physician** May 12, 2000 10:25 pm -dwara /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Yrs. October 30,1918 Director 220-98-6011 Egypt Usuel Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Directo Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 238 220 North Van Buren Street 20850 Funeral United States 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritei Status Black, White, etc. filed within 72 hours affac 1 Never Merried 2 N Merried 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 2 Owner Grocery Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be permit. Pages 1 and 2 should be to Department of Health and Mental important: If New 27 is marked or any Injury or other traumatic eve 2 Nasr Rizkalla Zahia Abdel-Malek 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naguib Rizkalla/ Son 6 Grandin Circle Rockville, Maryland 20851 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Gate of Heaven Mausoleum 2000 4 □ Donation 5 🖾 Other (Specify) Entombment Silver Spring, Maryland Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Furteral Service License M00335 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Cardiogenic Shock One Week Examiner Due to (or as a consequence of): Physician/Medical Examiner Ischemic Cardiomyopathy Years physician and s the burial-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): USB BS P.O. Pert ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown The law requires that Diabetes Millitus Records, by sign be 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy Chronic Renal Failure page 2 is certificate t 1 TYes 2 NO 1 ☐ Yes 2 ☐ No Hypertension Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the tuneral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturei 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier Medical (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 10 un May 13, 2000 D 20400 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 3941 Ferrara Drive Wheaton, Maryland 20906-4709 Mark Rosen, M.D. 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State 2000 17

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 0710 may 14 2000 Gileford Thomas Rigney /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Harford Fallston Fallston General Hospital If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Published (Month, Day, Year) Published (Month, Day, Year) West Virginia If Under 1 Yaar 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplaca (Steta or Foreign Country) **Funeral** 1 MM 2□ F Months Days Yrs. Director 235-30-9952 73 Usual Residence of Deceden 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow 1 ☐ Yas 2 No Director Abingdon Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 3725 Sewell Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yas 2 □ No WWII If Yes, Give Yaar or Datas: Korean 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygians. Important: if them 27 is marked other than "instrumit, or them bolds. 1 Never Merried 22 Married Specify: White 1 Yas 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Military 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middla, Last) Mable (u/k) Belcher Millard Lee Rigney 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 3725 Sewell Rd., Abingdon, MD 21009 Liselotte Rigney/ Wife 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 【Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5-17-00 Towson, Maryland 22. Nama and Addrass of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 23a. Peril. Enter the clease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications are caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications are caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications are caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications are caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications are caused the death. Approximata Intarval Between Onset and Death **Physician** Immediata Cause (Final diseasa or condition resulting in death) /Medical chronic bronchitis, emphy sema Examiner Dua to (or as a consequence of) Examiner 1 week respiratory failure physiclen and s the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, hypoxemia respiratory acidosis Physician/Medical Dua to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peripheral arterial insufficiency 24b. Were eutopsy findings evailable prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yas 2 No certificata Division of Vital After this certifical funeral director, p or Attanding Physician: 25. Was casa referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: Afta completely filled in by the fune 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide 1 Certifying Physician: Ty tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

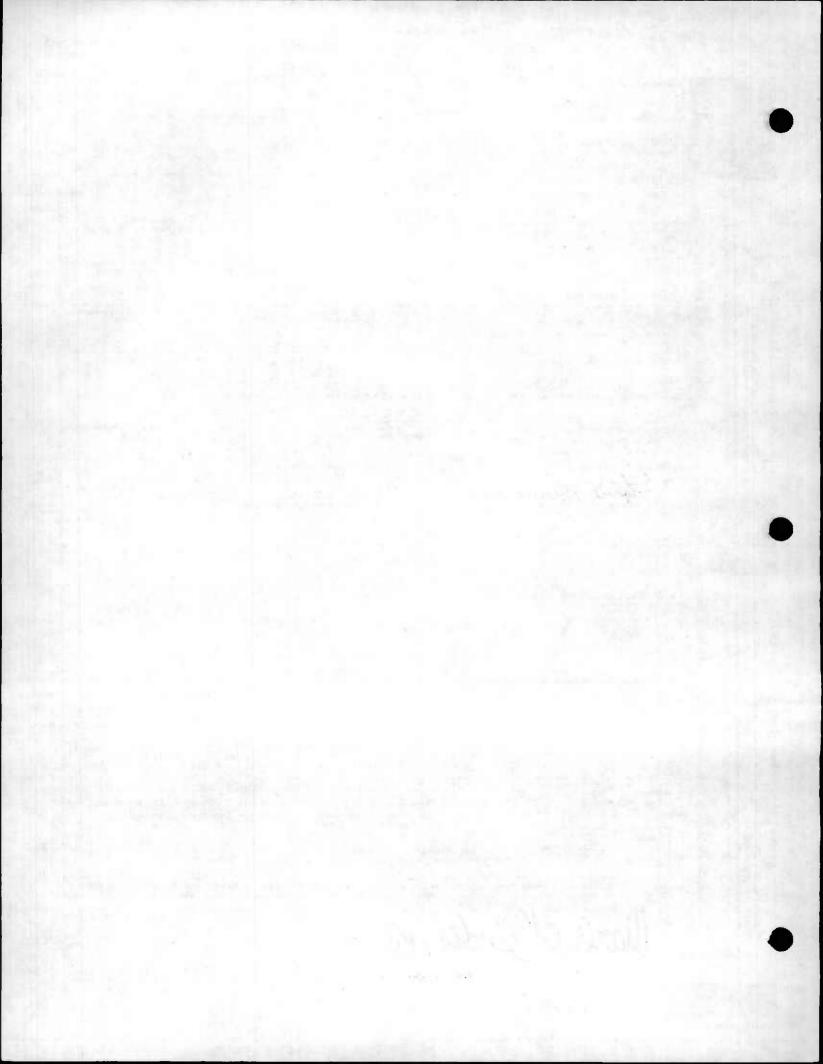
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner are stated. 29a. Certifier edical (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certil 29c. License number May - 14 - 2000 D18424 BXI 30. Nama and address of person whe completed cause of deeth (Item 23a) (Type, Print) B.D. Parekh 1908 MD Harford Road, Fallston mD 32 Proistrer's Signeture Registrar

Rigney, Gileford

MAY 18 2000 pours 10 Stones

State of Maryland / Department of Health and Mental Hygiene \(\cap \cap 17388\)

			Cert	tificate	of .	Death			Reg. No.	0 1	1000		
	Decedent's Name (First, Middle, Last)							2. Date of De	of Death 3. Time of De				
Jane Elaine Rodge							May	16,	2000	1015am			
4a Facility Name (If not institution, give	e street end number)					4b. City, To	wn, or Lo	ocation of Death	4c. Co	ounty of Death			
Casey House	5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Und									tgomer	У		
					1 Year Deys	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth	place (Stete or Foreign		
507-05-5760 May 10										3 IL	•		
Usual Residence of Decedent											10d. inside City Limits		
											1 ☐ Yes 2 ☐ No		
Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of V										n of What Cou	intar?		
										ted States			
9811 Veirs Dr. #3	12. Was Decedent	Ever In U.S.	13 W			dispante Orie	nin? (Sp			Race - Amer			
1 Never Married 27 Married	Armed Forces		if	Yes, specif	ify Cub	an, Mexican	, Puerto	ecify Yes or No Rican, etc.)		Black, White			
3 Widowed 4 Divorced	If Yes Give					Specify:			S	pecify: Whi	te		
15. Decedent's Ed	ducation	16a	. Decede	ent's Usual	Occup	oation			16b. Kind	of Business/I	ndustry		
(Specify only highest gra	ide completed)	5	(Give k	ind of work O NOT use	k done e retire	during most d)	of work	ing					
Elementery/Secondary (0-12)	College (1-4or	5+)	Н	omema	ker								
17. Father's Name (First, Middle, Last)					_	r's Name	e (First, Middle,	Maiden Su	ımame)				
Terry Royal Oberg						Mari	on S	tevenso	n McK	enna			
19a. Informant's Name/Relationship (7		199	b. Mailing	Address	(Street	and Numbe	er or Run	al Route Numb	er, City or T	own, State, Z	ip Code)		
Donald Rodgers /H	lusband	98	11 V	eirs	Dr.	#3,	Rock	ville,	MD 20	850			
20a. Method of Disposition		20b. Place of	of Dispos	ition (Nematory or off	e of	ogl	124	Date ay 18	20c. Loca	tion - City or T	Town, State		
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify									D - 1 -	. 1 1	100		
21. Signature of Funeral Service Licen		Chesa	-			ss of Facilit		000	Beltsville, MD				
· QHOXO	7							emation	Serv	ices			
933 Gist Ave. Silver Spring, MD 209													
23a. Part1. Enter the disease, or companies shock, or heart failure. List only	one cause on each l	ine.	not enter	r the mode	or dyn	ng, such as	cardiac (or respiratory a	rrest,	1	Approximate Interval Between Onset and Death		
Immediate Course (Fine)											Criset and Death		
Immediate Cause (Final disease or condition resulting in death)	a Multi-infarct Dementia 4 years									4 years			
		Due to (or as a	consequ	ience of):									
b													
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):												
cause. Enter Underlying Cause (Disease or injury	C.												
that initiated events resulting in death) Last	Due to (or as a consequence of):												
	I d.												
										1			
Part II. Other significant conditions of	her significant conditions contributing to death but not re					37							
					10	☐ Yes 2 [™] No 3 ☐ Probably 4 ☐ Unkr							
								24a Was	en autones	24h \	Vere autopsy findings		
								parformed? available prior to completion of ca			vallable prior to completion of cause		
											of death?		
							100	10	Yes 2 X	No 1	☐ Yes 2☐ No		
25. Was case referred to medical examiner?	Hospital:				04			h (Check only					
1 ☐ Yes 2√ No	1 U Inpati	ent 2 ER/O			A		rsing Ho		-		Hospice_		
27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of inju	ly Year) 28b.	Time of injury		Bc. Injui			28d. Describe	how injury	occurred			
2 Accident investigation 3 Suicide 6 Could not be	2 Accident investigation M 1 Yes 2 No												
4 Homicide determined	289. Place of In	jury - At home, f c. <i>(Specify)</i>	arm, sfre	ef, factory,	office			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
(Check only 2 Medical Exam	ysician: To the best niner: On the basis o	f examination as											
one)	and manner st	afed.			12555				204 5-1-	-1	Day March		
29b. Signature and title of cartifier	VC	1h	100	290.	LICONS	se number			// A	signed (Mont/	i, Day, rear)		
Maun	1.000	MC	10) DO	037	620			Ma	4 17	2000		
30. Name and address of parson who	completed cause of							200) = =				
Mark S. Godec M.	D. 6001 1	Muncaste	er Mi	111 R	d. 1	Rockvi	111e	, MD 208	355				
31. Date filed (Month, Day, Year)		rar's Signature	1	- 1									



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 15, 2000 May 8:40 am Thomas Rutkoski /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Aug 25, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 12 M 2□ F Yrs. 1948 Maryland 51 Director 215-54-8527 Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2X No Directo Silver Spring Maryland Montgomery r than "natural", or hama 23a or 28a-f the Medical Examiner must be notifie 8 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA 13523 Westwind Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedant Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: py 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Hygiene. other then "n Elementery/Secondary (0-12) College (1-4or 5+) Disabled 4 Unemployed permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygie important. If Item 27 is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middla, Last) Be 2 Teddy Rutkoski Margaret Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) Teddy Rutkoski / Father 207 Timberwood Avenue, Silver Spring, MD 20901 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 5/19/00 20c. Location - City or Town, Stata W Burial 2 ☐ Cremation 3 ☐ Removal from State Burtonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Burtonsville Union Cemetery 22. Name and Address of Facility 21. Signature of Funaral Service Licensea Francis J. Collins Funeral Home, Inc. ten 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feiture. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 10 disease or condition resulting in death) Examiner ure 10 8yndrone Due to (or as a consequence of): Examiner physician end s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 edical Due to (or as a consequence of): Physician/M for 23b. Did tobacco use contribute to the causa of death? ed by the detached Records, P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t d be detact 1 Yee 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed been certificate has 1 Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. tnjury at Work? 28d. Dascribe how injury occurred Certification: After al or Attending P s after death. If Director: After ed in by the funer ↑ BNeturai 2 Accident 5 Panding investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date and placa, and due to the cause(s) end menner es stated. edicai

10

State Registrar

Fentan 630 31. Data filed (Month, Day, Year) 19 2000 MAY

(Check only one)

8

29b. Signature and title of certifier

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Street 32. Registrar's Signature

Medical Examiner: On the basis of examinetion and/or Investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) and manner steled. 29c. License number

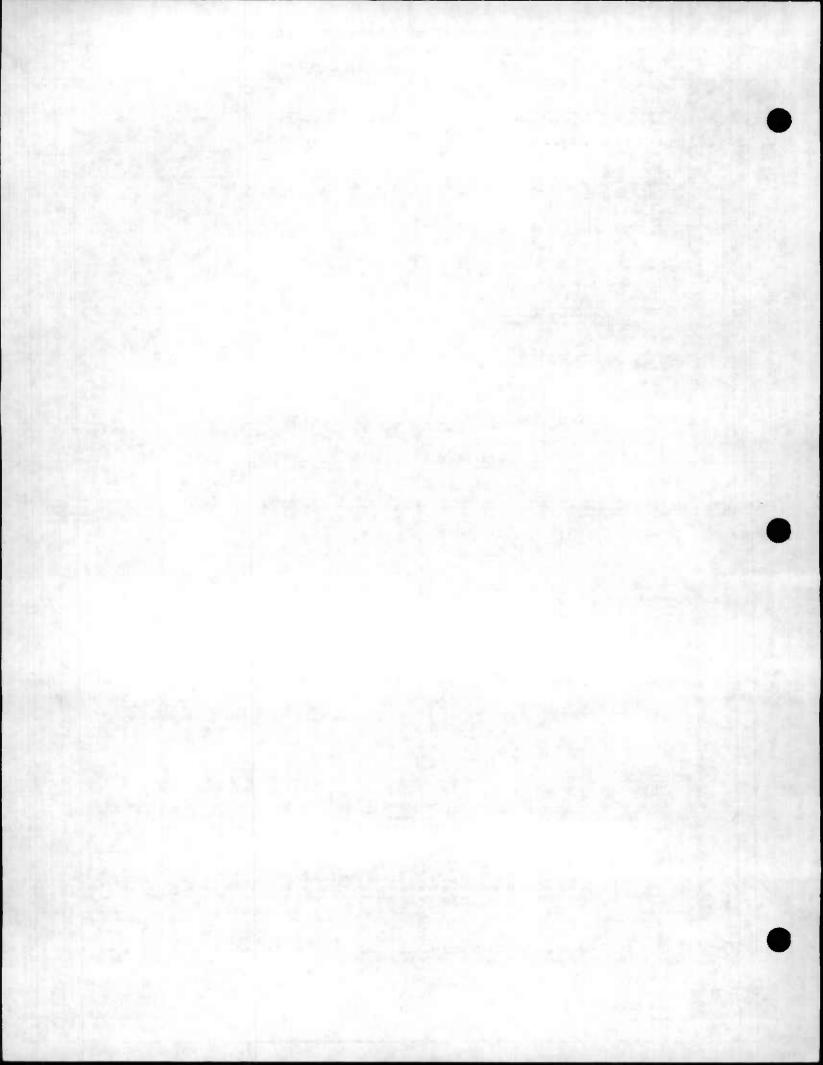
29d. Date signed (Month, Dey, Year)

MD

Lynette_Posorske, MD

00

20910



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Deeth Dey **Physician** Alberta Frances Ryan 11, 2000 May 12:10 am /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mariner Health - Kensington Kensington
| If Under 24 Hrs. | 8 Montgomery If Under 1 Yeer 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2₽F Months Days Hours Min Yrs. Director 578-50-1623 Jan. 20, 1908 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Menylai Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23s or 28s-f show many or other treumatic event, the Health Examiner must be notified an enter. 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10122 Hereford Place Funeral 20901 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give **
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Bleck, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be 10 Albert Newton Brown Ida Victoria Aronholt 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 911 Kerwin Road Robert L. Ryan (son) Silver Spring, Maryland 20901 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 5/15/00 Rockville, Maryland 21. Signature Funeral Service Licens 22 Name end Address of Fecility
Francis J. Collins Funeral Home, Inc. oke 500 University Blvd., W., Silver Spring, MD 20901 23e. Pert1. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each lin Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Fine) disease or condition resulting in death) /Medical a Malnutrition vears Examiner Due to (or es a consequence of): Examiner Functional Gastro-esophageal Disorder vears The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical Due to (or es e consequenca of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dtd tobacco use contribute to the cause of death? s been signed by the 2 should be detache 3 Probably 4 Unknown 1 ☐ Yes 2 € No Chronic Obstructive Pulmonary Disease þ Records, 24b. Were autopsy findings evailable prior to completion of cause of deeth? Be Completed 24e. Wes en autopsy performed? Depression page 2 1□ Yes 2□ No 1 ☐ Yes 2 No certificate Osteoarthritis, Division of Vital Osteoporosis Attending Physician: director, 25. Was case referred to medicet examiner? 26. Plece of Deeth (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 topatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No this 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of After 1 Netural 5 Pending n 24 hours efter death.

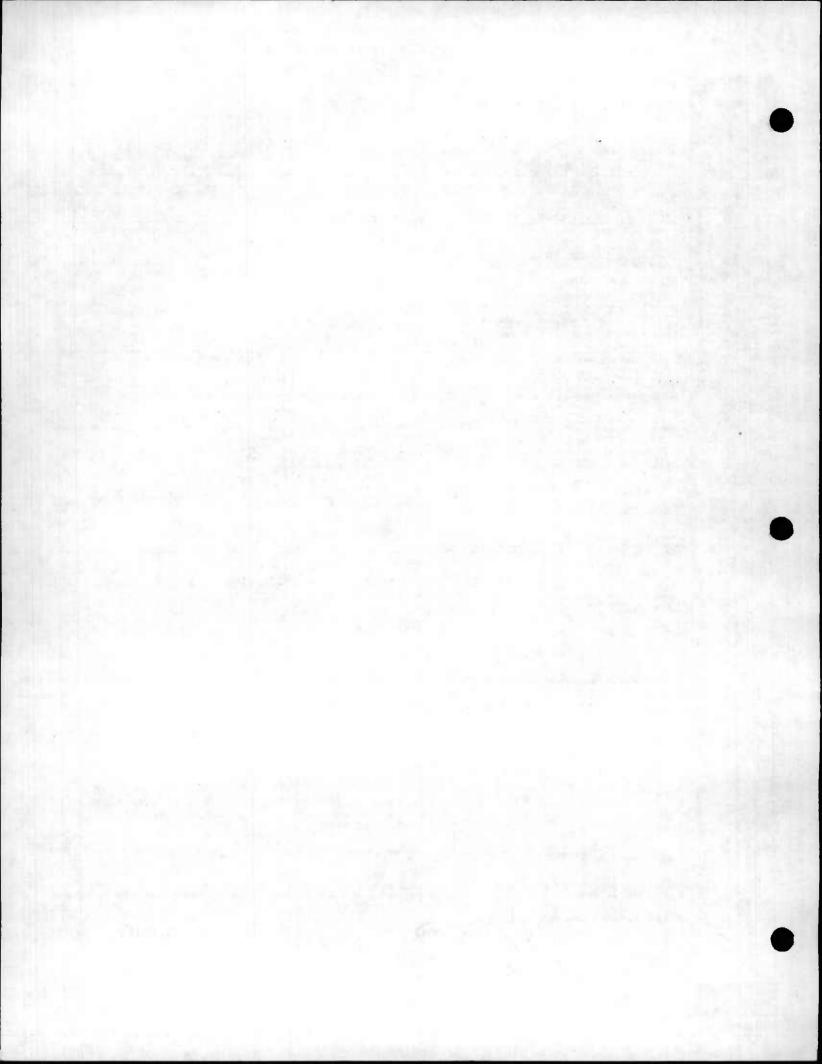
Ne Funeral Director: Alphabetely filled in by the fa death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 6 29e. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the edical To the Hosp within 24 hor To the Fune completely fi Iner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and/mainer stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number 5/16/00 Wi D 16495 30. Name and address of person who completed dause of deeth (Item 23a) (Type, Print) 4701 #105 Rockville, Maryland Joel Goozh, M.D. Randolph Road 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

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souls

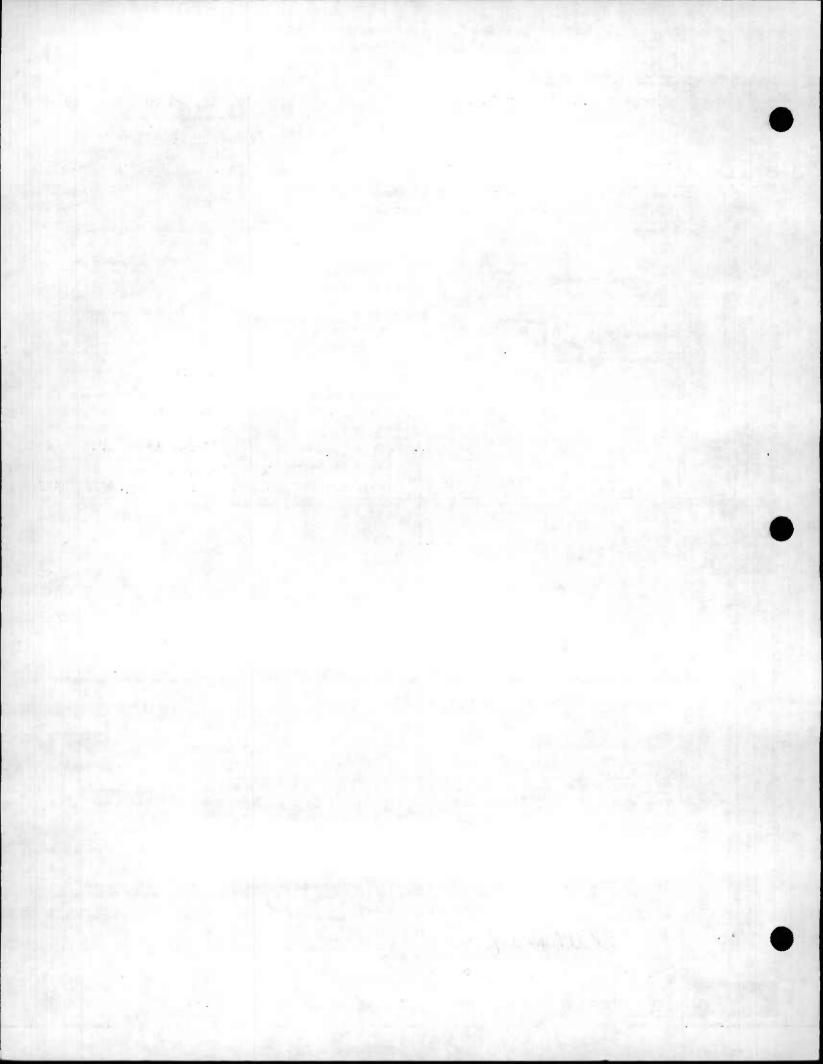


State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death Reg. No 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Martha M. Ryland May 16, 2000 7:30pm /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Gaithersburg 401 Russell Ave #204 Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** Deys Months 1□M 2☑F 579-40-2043 Yrs. 93 Director Aug. 4, 1906 West Virginia Usual Residence of Decedent 10a Stete 10c. City, Town or Location ahow 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Meniel Hygiene. Important: if Itam 27 is marked other than "natural", or itams 23s or 28s-1 show any injury or other treumatic avent, the Medical Exercises must be notified as page. 1 Ves 2 No Director Md. Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Russell Ave 20877 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 M Widowed 4 □ Divorced No Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Medical Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surnama) Be Rose Ellen DeVore Algernon Thomas Pyles 10 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 227 Hugh St. Moorestown, NJ. 08057 Doris M. Gilmour (Daughter) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata May 19 1X Burial 2 ☐ Cremation 3 ☐ Removel from Stete Suitland, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 2000 22. Name and Address of Facility DeVol Funeral Home 21. Signeture of Funerel Service Licenset urtes 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teiture. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Finat disease or condition resulting in death) Pulmonary Edema Days Examiner Due to (or as a consequence of): Examiner Renal Failure Months attending physician and for use as the burlal-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): P.O. Box 68760. Myeloma Months Physician/Medical Due to (or as a consequence of) signed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobecco use contribute to the cause of death? 1 ☐ Yee 2 ☑ No 3 Probably 4 Unknown Hypothyroid, Hypertension Records, þ 24b. Were eutopsy findings available prior to complation of cause of death? should Completed 24a. Was en autopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificeta Division of Vital or Attanding Physician: 80 25. Wes casa rafarred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 5 Pending investigation 1 X Neturel To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After completely filled in by the fun. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Ptece of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29e. Certifier Medical (Check only one) 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) luda 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D41794 May 17, 2000 Priscilla Callahan-Lyon, M.D., 911 Russell Avenue, Gaithersburg, MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Depera MAY 18 2000

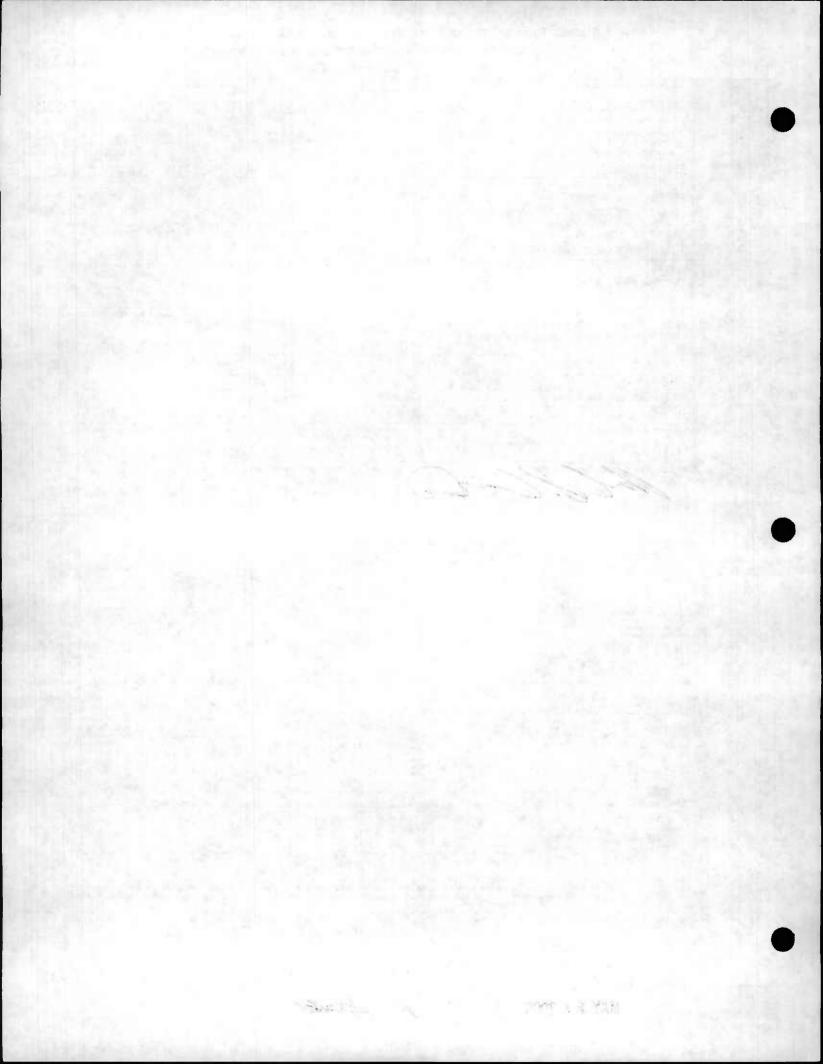
Registrar



State of Maryland / Department of Health and Mental Hygiene 39 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 20, 5:23PM LOLITA G. SMITH MAY 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F Months Days Hours Director 578 36 3045 82 PUERTO RICO Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location Show 10d. inside City Limits treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MARYLAND 288-1 ANNE ARUNDEL **EDGEWATER** 10f Zin Code 10g Citizen of What Country? 10e Street and Number Herna 23a or 3946 HONEYSUCKLE DRIVE 21037 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. filed within 72 hours after I ☐ Yas 2 ☑ No If Yes, Give X Year or Datas: 1 Never Married Married 5 Baltimore, Maryland 21215-0020 1 XYes 2 No Specify PUERTO RICAN þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY FEDERAL GOVERNMENT pemit. Pages 1 and 2 should be file Department of Haalth end Mental Hy Important: If Nem 27 is marked othe eny Injury or other treumants asser-18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOVO GONZALEZ CARMEN AND TNO 2 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JESSIE S. HALFPAP (DAUGHTER) 5910 TYLER ROAD DEALE, MD. 20751 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Data 1 ☐ Burial 2X3Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 05-22-00 ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatura of Funcial Sarvice Coun GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Cause (Final diseasa or condition resulting in daath) /Medical Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trer Dua to (or as a consequence of): pue Box 68760. physician Physician/Medical the Dua to (or as a consequence of) 82.00 USB P.O. Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 20,10 of Vital Records. þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed page 2 certificate has 1 Tes 1 Tes To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; E Be 25. Was case rafarred to medical examiner? 26. Placa of Death (Chack only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 30 No Medical Certification: To 1 Yes 1 2 Inpatiant 2 ER/Outpatient 3 DOA 28a Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 2000 30. Nama and address of person completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 2 2000 Registrar



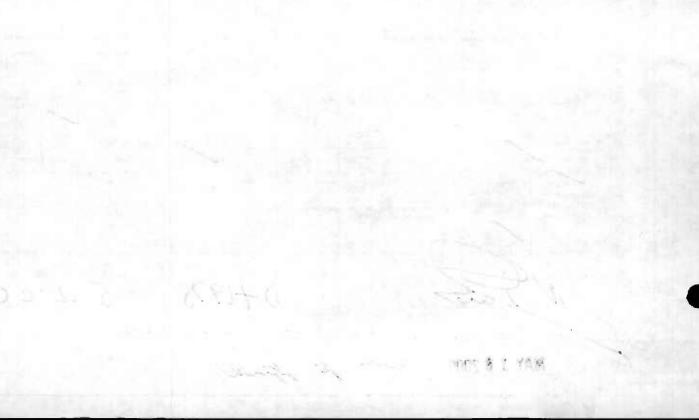
	Certificate of Death		g. No.	17393									
Physiciar	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death 5:00 am									
/Medica Examine	THOMAS E. SIMMONS SR. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Lo	MAY 13 cation of Death	A1 13 2000										
Funeral Director	1283 GRAFF COURT APT 1 A 5. Sociel Security Number 220-22-6741 ANNAPOLI 7. Age (In yrs. last birthday) Yrs. ANNAPOLI 1 H Under 1 Yeer 1 f Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey,		UNDEL inthplece (State or Foreign Country) ARYLAND									
pu *	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits										
Maryl Haho	MARYLAND ANNE ARUNDEL ANNAPOLIS												
or 284	10e. Street and Number 10f. Zip Code	10	g. Citizen of What (Country?									
5-0020 72 hours after death with the Maryland natural', or items 23e or 28e-f show fical Examiner must be notified at	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ 947 — 50 1 ☐ Yes 2 ☐ XNo Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - An Bleck, Wi Specify: B										
	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of works)		6b. Kind of Busines	s/industry									
d 21215-0 flied within 72 ho thysiena." naturi ent, the Medical	Elementery/Secondary (0-12) College (1-4or 5+)												
be filed tal Hygid	12+h 0 GENERAL FOOD FOREMA 17. Father's Name (First, Middle, Last) 18. Mother's Name			ACADEMY									
Maryland 12 should be flie h and Mental Hy r is marked oth traumatic event	EDWARD SIMMONS	RUDE ROBINSON											
Mar d 2 sh d 2 sh h and 7 is m traum	19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rure CORDON B. STMMONS (CON)	al Route Number,	City or Town, State	21403									
re, n s 1 and r Health tem 27 other tr	GORDON R. SIMMONS (SON) 1283 GRAFF CT. APT. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetery, cremetery or other place)		NNAPOLIS Poc. Location - City of										
altimore, mit. Pages 1 at partment of Hea portant: If Nem: y Injury or othe		/19/00	CROWNSV	ILLE, MD.									
Baltime permit. Pag Department Important: In ony Injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A.												
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or shock, or heeft feiture. List only one cause on each line.	NAPOLIS or respiratory erre	S. MD. 2	1 4 0 1 Approximete Interval Between									
Physician	() -11 01	00 (Onset and Death									
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e. Use Myocardel information e.												
D #	Due to (or as a consequence of):												
60, be executed sician and bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter fundarlying Cause (Disease or injury c.												
68760 ficete be e physician is the bunia	Cause. Enter underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of):												
BOX 687 leath certificate attending physical for use as the													
D. B b death he after hed for	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld tol	bacco usa contribu	ita to the cause of death?									
P.O. what the ed by the detache	Frankly Reval diseas, gpt II drabite	1 1 Y	1 Yaa 20 No 3 Probably 4 Unkno										
The law requires that the death certificate be exacuted tale has been signed by the attending physician and agge 2 should be detached for use as the burishtransis.	Penghal I Apular disorder, Obesty	24e. Wes er perform		b. Were autopsy findings evailable prior to completion of cause ot deeth?									
		1 ☐ Ye	s 2000	1 ☐ Yes 2 ☐ No									
Of Vital Rec Physician: The law this certificate has ral director, page 2	25. Was cese referred to medical examiner?	. 1											
Physic or this co	1 Inpatient 2 Ervoutpatient 3 DOA 4 Nursing no		nce 6 Other (Since in the contract of the cont	Decity)									
auth. or: After he fun	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No												
DIVISION Of VIta Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director.	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, efc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)											
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred and manner stated.	end due to the ca red at the time, da	ause(s) and manner ate end place, and c	as stated. lue to the cause(s)									
To the within To the comple	29b. Signature and title of cartifier 20c. License number 20c. License number	> 29	9d. Date signed (Mo	onth, Dey, Year)									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33 A. Porce	. BKE	Arrai	10416 Pm									
State Registrar	31. Date tiled (Month, Day, Year) 32/Registrar's Signature 9.												

State of Maryland / Department of Health and Mental Hygiene 394 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 12, Mary L. Spasaro 2000 9:55 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health & Rehabilitation Annapolis Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□ M 2₽F Vis 212-78-6915 Director May 29,1912 Washington, D.C. Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Director 28a-f Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 ma 23a or 99 Mansion Drive 21403 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married b Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: 3 N Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filled within Hygiene. other than and, the Me Elementary/Secondary (0-12) 8th College (1-4or 5+) Homemaker parmii. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked olth any lirjury or other traumatic event bass. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gregory Segreti Maria Pate 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 99 Mansion Drive Annapolis, Nancy A. White/ Daughter Maryland 21403 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremetion 3 ☐ Removal from State Gate of Heaven Cemetery 5-16-00 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetyre of Funeral Service Pic 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure months Examiner Due to (or as a consequence of): Examiner Right lower extremity deep vein thrombosis sician and burial-transit weeks The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. attending physician for use as the buria chronic renal insufficiency weeks Physician/Medical Due to (or as a consequence of) P.O. I signed by the at the detached for Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? page 2 should 24a. Was an autopsy performed? this sertificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 BNaturat 5 Pending investigation To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) おおり 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edical 29a Cortifio In: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29b. Signature and Me of of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add al pared who completed cause of death (Item 23a) (Type, Print) Nader Tavakoli. M.D. 1 Hospital Drive Cheverly, Maryland 20785 51. Date tiled (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Regist ar

MAY 1 6 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2000 **Physician** /Medical 45 City, Town, or Local 4a Facility N ame (If not institution, give street and number) ion of Death 4c. County of Death Examiner NNA OL true If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) July, 27 1909 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Deys Yrs. Director 565-05-0809 Philippines Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 □YYes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Chesapeake Ave. 21403 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1€ Yes 2 □ No If Yes, Give Year or Detes: 1942—1945 11. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "na any injury or other traumatic event, the Healt Page. Elementary/Secondary (0-12) College (1-4or 5+) Education Asst. Professor Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 George W. Satterthwaite Dolores Tiscar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Francis G. Satterthwaite/Son 915 DelMonte Blvd. Pacific Grove, CA. 93950 20a. Method of Disposition 20b. Ptece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 05-15-00 Annapolis, Maryland 21. Signeture of Funeret Service Licent 22. Neme end Address of Fecility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** NTRACENEBRAL Fewery Immediate Cause (Finet disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): P.O. Box 68760, attending physician for use as the burls that initiated events resulting in death) Last Due to (or es a consequence of) Pert II. Other significant condi contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. ģ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: Atter this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State Registrar

Medical

5 2000

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Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s)

29d. Dete signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 17396

Certificate of Death

					Certifica	te of i	Death		F	leg. No.			10		
	1. Decedent's N	edent's Name (First, Middle, Last) 2. Date of Death Month Day Year								Year	3. Time				
hysician /Medical	ED	EDWARD F. STAUB							MAY		2000	15.	30		
Examiner	4a Facility Nam	e (If not institution, gi	va street and number)			4	b. City, To	wn, or Lo	ation of Death	4c. County	of Deeth				
	Union M	Memorial H	ospital					imor				7.5			
uneral rector	5. Social Sacurit	*	Sex 7. Age 1∬2 M 2 □ F	(In yrs. last bir	Yrs. If Unda Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Sept. E	Year) 1935	9. Birthp Coun Mar	lace (State try) y Land	or Foreign		
	213-32-0993 Sept. 8, 1935 Marylank														
show of at	10a. State 10b. County 10c. City, Town or Location										1	0d. inside	Olty Limits		
notified rector	MD Anne Arundel Severna Park										1 ☐ Yas 2 ☐N Og. Citizen of What Country?				
r itema 23e or 28e-1 s from must be notified Funeral Director	10e. Street and Number 10f. Zip Code									10g. Citizen of \	What Coun	itry?			
a le	607 Rito	chie Highw	ay	21146						USA					
Je L	11. Maritai Statu	JS	12. Was Decedent E	var in U,S.	13. Was Deco	dent of H	ispanic Origin, Mexican	gin? (Spe	cify Yes or No-		e - Americ		11		
b A	3 ☐ Widowe	larried 2 Married	1 Yes 2 No If Yes, Give Year or Datas:	1□ Yes		Specify:		, στοι,	Black, White, etc. Specify: White						
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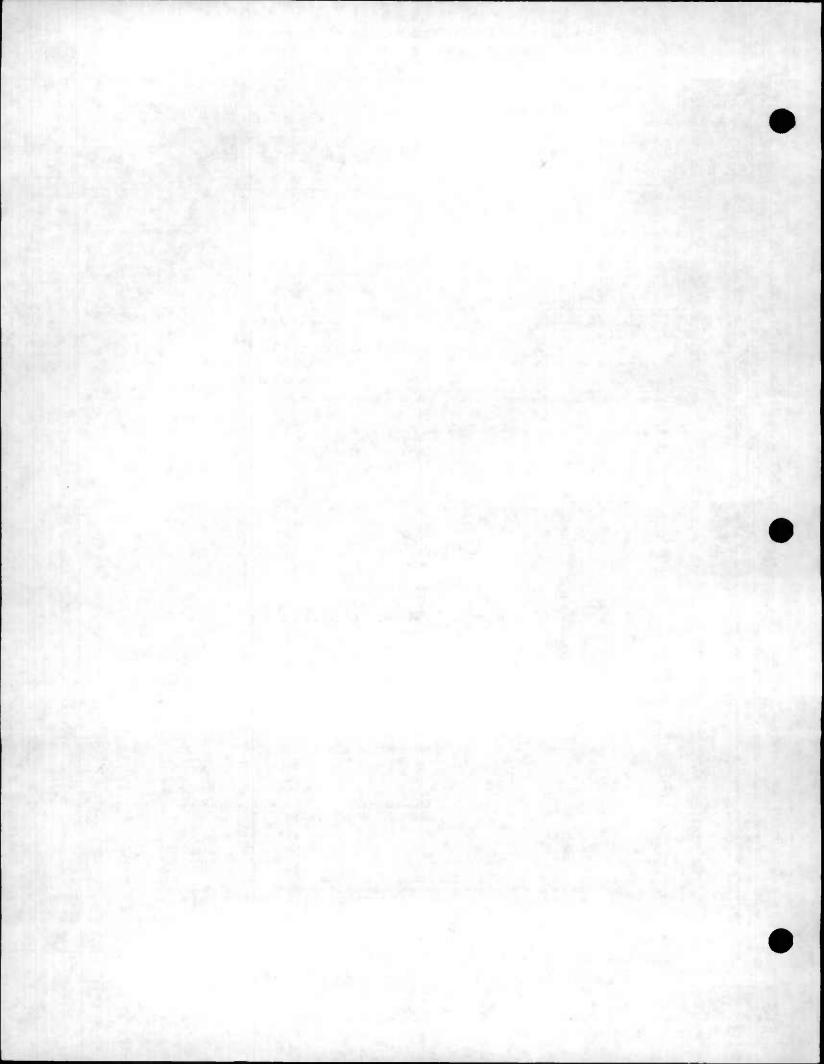
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State of Mai

ryland /	Department of Health and	Mental Hygiene	0	0	010
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								Death			Reg. No.			
- 1	1. Decedent's Name	(First, Middle, L	Last)							2. Date of Dea	ath Day		Year	3. Time of Death
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iner	4a Facility Name (If						4	b. City, To	wn, or Lo	cation of Death		County o		
	ST. AC	NES HOS	PITAL					BALT	TMOR	E CITY				
il .	5. Social Security N	umber 6.	Sex	7. Age (In	yrs. last birthday	If Under		If Undar	24 Hrs.	8. Date of Birt	th Your		9. Birthp	laca (State or Foreig
	218-60-58	54	1 M M 2□ F	4	5 Yrs.	Months	Days	Hours	Min.	June 1	3,195	54	Mary	
	Usual Residence of	Decedent												
	10a. Stete	10b. County		100	c. City, Town or L	ocation							1	0d. Inside City Limit
Director	MD	Baltin	nore		Baltimo	re								1 ☐ Yes 2 🖁 N
ا ځ	10e. Street and Num	nber				10f. Zip	Code				10g. Citiz	zen of W	hat Coun	try?
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runeral	11. Marital Status	-	12. Was Dec	cedent Ever	in U,S. 13.	Wes Deced	dent of H	ispanic Or	igin? (Sp	ecify Yes or No Rican, etc.)	- 1			an Indian,
	1 Nevar Marrie	ed 2 Married	Armed F	2 1 No					n, Puerto	Rican, etc.)		Black	k, White,	
	3 🗆 Widowed		If Yes, G Year or I	ive		1□ Yes	2 / □ No	Specify:			1	Specify:	B1:	ack
I		15. Decedent'a	Education		16e. Dece	dent's Usue	el Occup	ation			16b. Kin	nd of Bus	siness/Inc	dustry
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	17. Father's Name (First, Middle, La	st)		THE CH	OLK II	ا		ar's Name	(First, Middle,	Maiden S			
	Donald D.									Neal	The last			
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	20a. Method of Disp	osition Cremation 3	☐Removal from		camatery, cre	matory or o	ther plac	ce)		Data	20c. Loc	cation - (City or To	wn, Stata
l		5 Other (Spec		Ciuro	MD Natio	nal C	emet	ery	5,	/18/00	Lau	irel	, Mar	ryland
-	21. Signature of Fur	neral Service Lic	ansee	Mod	7/// 2	2. Name an	nd Addres	ss of Facili	ty Wit	zke Fu	neral	1 Ho	mes,	Inc.
) The	. A. Z	1	1000	1771	630 E	dmon	ndson	Aver	nue, Car	tonsv	vi11	e, M	D 21228
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	shock, or heer	t failure. List on	ly one ceuse on	each line)	Interval Between
J6	Immediate Cause (I disease or condition resulting in death)		ð	CA	EDIAC TA	MICUA) quenca of):	DE							Onset and Death
VMedical Examiner	disease or condition	nditions, mediate riying injury	a	CAI Due L Due Ryptu		quenca of): AVCIÙ quence of): T(C)	m	CTICN	J					
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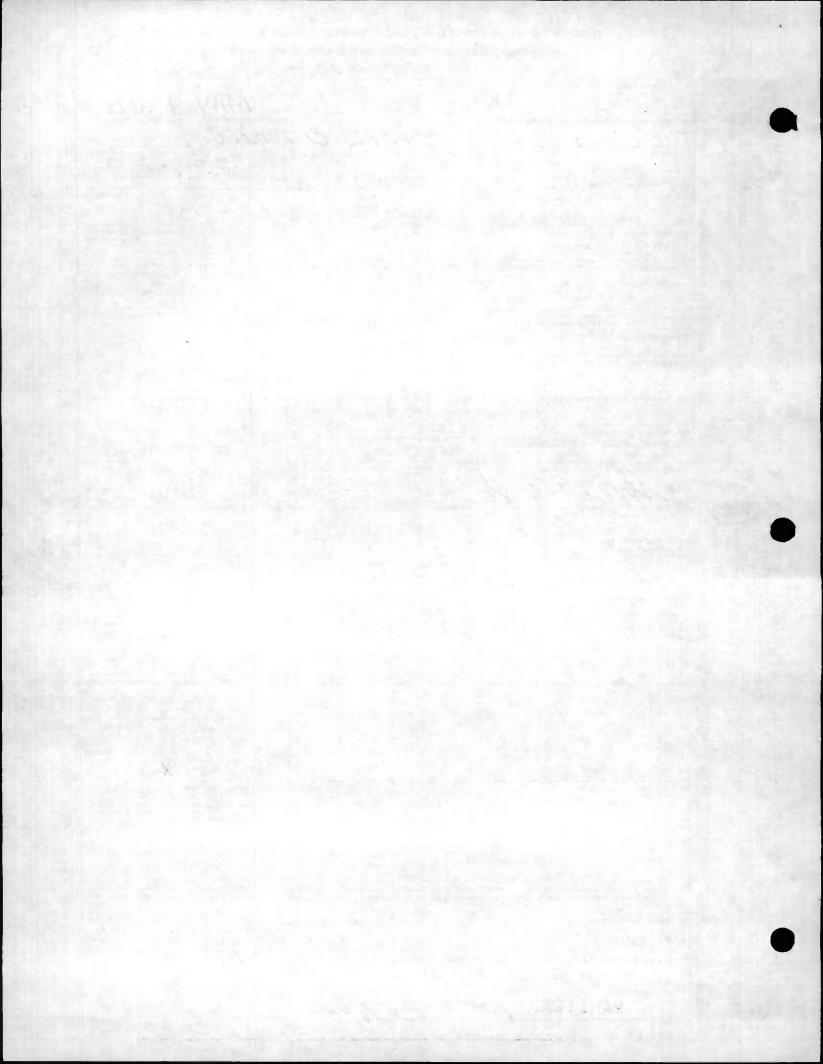


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Name (First, Middla, Last) **Physician** 21A1 /Medical 4c. County of Death 4b. City, Town, or Location of De Nama (If not institution, ai Examiner If Undar 1 Yaar Months Days If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Social Security Number 7. Aga (In vrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Hours 1 M 2 F 212-48-8346 53 Director 14, 1947 Maryland March Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d Inside City Limits ty Yas 2 No Bel Air Harford Director Maryland or hams 23a or 28a-4 idical Examiner must be notifi 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda USA 31 Apt. A, Huntington Place 21014 Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. I □ Yas 2 🔯 No If Yas, Giva Yaar or Datas: nours after 1 Nevar Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: White À Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry filed within 72 il Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Automotive Service Writer 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Pages 1 and 2 should be sent of Health and Mental int: If them 27 is marked or Helen Elizabeth Hopkins James Lester Spicer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 708 Orley Place, Bel Air, MD 21014 Stephanie E. Sewitsky/Daughter Department of Health Important: If Item 27 Baltimore, 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c Location - City or Town State cematary, cramatory or other placa) 1 Burial 2 □ Cramation 3 □ Removal from Stata 4 □ Donation 5 □ Othar (Specify) Bel Air Mem. Gardens 5/12/00 Bel Air, MD 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014 23a. Part1. Enter the disease, or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transit Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated execute. Box 68760. that initiated events rasulting in death) Last as for use ed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 | Yas 2 | No by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? page 2 should Completed complation of causa of death? this certificate has 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa raterred to medical axaminar? Be 26. Placa of Death (Chack only ona) Hospital: 1 Impatient Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas ₹ No Certification: To 2 ER/Outpatient 3 DOA septal or Attending Physhours after death.
noral Director: After this y filled in by the funeral d 28a. Data of Injury (Month, Day 27. Manner of Deat 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Devatural 2 Accident 5 Pending invastigation 1 Yas 2 No 6 Could not be detarmined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral C Hospital 24 hours a edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier completely (Check only one) 29b. Signature and file of certifie 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print), 0 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 1 1 2000 MAY Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedant's Name (First, Middle, Last) 2000 N 4b. City, Town, or Location of Death County of Death 4c. 40 Wara 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days -28 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. insida City Limits 1 ☐ Yes 2 ☑ No Abingdon Maryland Harford 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 801 Eastridge Road 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritel Stetus 1 XYes 2 No If Yes, Give Year or Dates: 1951 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 1955 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Electrician Soap Manufacturing 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Grace Geraldine Funk John Martin Sears, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Dolores Sears/Wife 801 Eastridge Road, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/11/00 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 21009 1317 Cokesbury Road, Abingdon, MD 23a. Part. Enter the disease, or complications the caused the deeth. Do not estack, or than failure. List only one cause on each line. Approximate interval Between Onset and Death immediate Cause (Final WITH WEAM CTION! JAMUTES disease or condition rasulting in death) Due to (or as a consequence of) Due to (or as a consequenca of) Due to (or as a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 □ Unknown 1 ☐ Yee 2 ☐ No CELEBROIMSCULAR DISEASE 24b. Were autopsy findings available prior to 24a. Was an autopsy DIABETES MELLITUS completion of cause of death? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Rasidenca 6 ☐ Other (Specify)

Physician /Medical Examiner

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certificate

After this funeral

after death. Director: Aft

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The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

Hospital or Attending Physician:

Examiner

Physiclan/Medical

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25 Be

Physician

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item 27 is marked other than "natural", or items 23a or 28e-f shoother traumatic event, the Medical Examinal must be notified at

Pages 1 and 2 should be filed within 72 hours efferment of Mealth and Mental Hygiene.

il Hygiene.

Department of) Important: If its

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any injury

Maryland 21215-0020

altimore,

with the Maryland

death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or trijury that initiated evants resulting in death) Last

Was case referred to medical			26. Placa of Death	(Chack only
examiner?	Hospital:		Other:	

1 Yes 2 No 27. Manner of Death

1 BNatural

2 Accident

3 Sulcide

29a. Cartifian

4 Homicida

28a. Date of Injury (Month, Day Year) 5 Panding investigation

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28b. Time of

28c. tnjury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the causa(s) end menner stated. 29c. License number

29b. Signature and title of certifian 1. Welrarden ro

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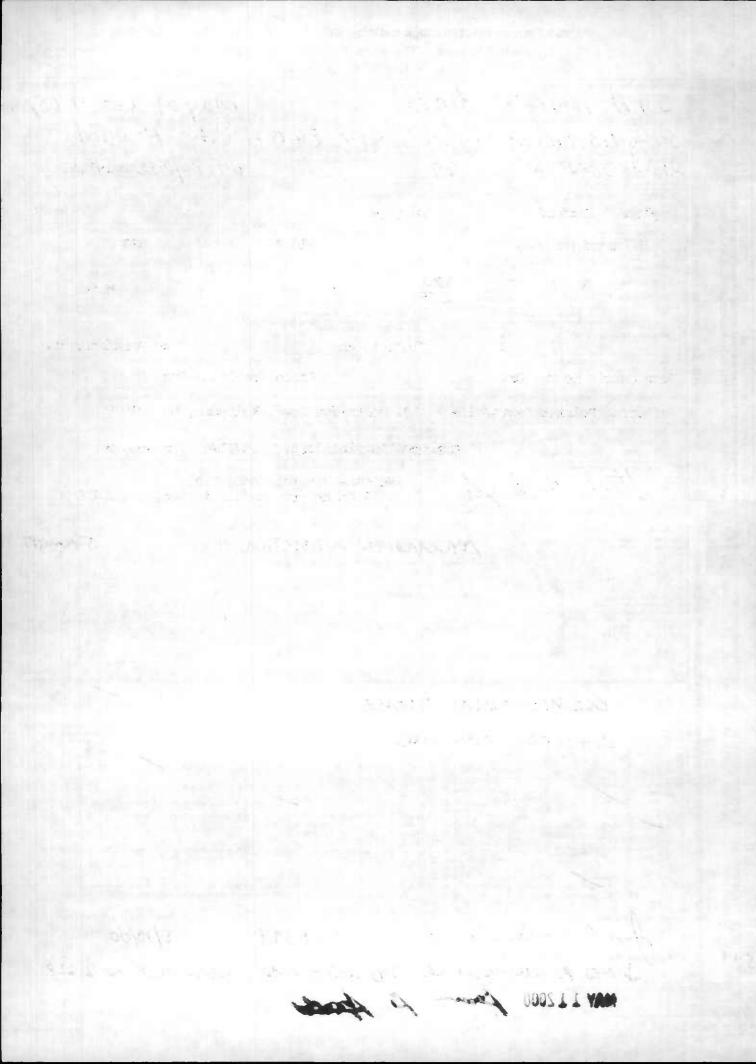
29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

CATONSVILLE MD 21228 RICHARDSON M.O. GEIPE BOAD 700 31. Date fited (Month

State Registrar

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Day Month **Physician** 1, 2000 LOUISE W. May 5:25 PM SCOTT /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Harford Hart Heritage Home Street 7. Aga (In yrs. last birthdey) If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Sacurity Number **Funeral** Days 1 □ M 2 X F Yrs. Director 87 163-38-2126 06/03/1912 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. Stata 10b. County 10d. inside City Limita perms. Pages 1 and 2 should be filed within 72 hours after death with the Maryfan Department of Health and Mental Hygiene. Immortant if fire 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat mad the notified at PA York FAwn Grove XXX 2 No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 246 East MAin Street 17321 USA Funerai 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, White, etc. 1 Yas XXNo If Yes, Give Yaar or Detes: 1 Naver Marriad 2 Married altimore, Maryland 21215-0020 1 Yas 210 No Specify: Specify: White P 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) 2 years Homemaker 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be Nathaniel John Wise Ida Myers 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Dorothy M. Barbour-daughter 240 Buckwheat Rd., FAwn Grove, PA 17321 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 120 Kurial 2 Cramation 3 Ramoval from Stata FAwn Grove Cemetery 5/4/2000 Fawn Grove, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Harkins Funeral Home, Inc., Delta, PA

disease or complications liket caused the death, To not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximata Interval Between Onset and Daath **Physician** /Medical Immediate Cause (Final AMS. OSARCOMA ~YZAR disaasa or condition resulting in death) Examiner Dua to (or as e consaguence of): Examiner sician end burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Diseasa or injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of): physician s the burial Physician/Medicai Dua to (or as a consequence of): attending pl signed by the a Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings available prior to completion of causa of daath? been si 24e. Was an autopsy Completed After this certificate has funerel director, page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No Attanding Physician: ASSISTED CARE Be 25. Was casa referred to medical axaminar? 26. Placa of Death (Chack only ona) Other: 42 Nursing Homa 5 Residence 8 Other (Specify) 2 1 Yas 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Time of Certification: 1 Natural 5 Pending death. 1 Yas 2 No Investigation 2 Accident or Attance after deati Director: 6 Could not be datamined 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital or within 24 hours after To the Funeral Discompletely filled in 29a. Certifiar 1 💢 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and dua to the cause(s) and mannar as stated. edicai 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and mennar stated. (Check only one)

Records, P.O. Box 68760 Division of Vital

Registrar

3 2000

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signatura and titla of certifian Con o but mo

39889

2000

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

Alfred Sparks, M.D., 31. Data filed (Month, Day, Year)

MAY

32. Registrar's Signatura Much

MAcPhail Road, Bel Air, MD 21014 oaks

MULTER STORY STORY STORY 2 s 25s Marke at the mast service was to be a selected as were the first the street of t

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** May 1, 2000 12:50 PM Sylvia Bem Skillman /Medical 4e. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3710 Mill Road Abingdon Harford if Under 1 Yaar Months Deys If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 10 M 20 F Months Director 215-07-7962 83 Nov. 10, 1916 Maryland Usual Residence of Decedent the Meryland permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any hjury or other traumatic event, the Medical Examples must be notified and any other. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Harford Abingdon 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3710 Mill Road 21009 USA Funeral 12. Wes Decedant Evar In U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 14. Rece - American Indien, Bieck, White, etc. 1 Yes 2 No If Yes, Giva Yeer or Datas: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2☐ No Specify: þ Specify: 3€Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 11 Secretary U.S. Government 17. Fethar's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Melden Sumeme) Be Joseph (nmn) Bem Zelenka 2 Anna Bozena 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Arthur Skillman/ Son 3710 Mill Rd., Abingdon, Maryland 21009 20b. Plece of Disposition (Name of cametery, crematory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1⊠ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Francis de Sales Cem. 5-4-00 | Abingdon, Maryland 22. Neme end Addrass of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 place on the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, one chause on each line. 23a. Pert1. Enter the disease, or counshock, or heert feilure. List out Approximete interval Between Onset end Deeth **Physician** fmmediete Ceuse (Finel diseese or condition resulting in deeth) /Medical ASLUD Examiner Dua to (or es a consequence of): Examiner certificate be axecuted signed by the attending physician and d be datached for use as the buriel-trans Sequentielly list conditions, if any, leeding to Immediate causa. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequance of): P.O. Box 68760 Physician/Medical Due to (or es a consequance of) Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ cate has been signated; 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Wes an eutopsy certificate has 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital saptal or Attending Physician: Thous after deeth.
neral Director: After this certificat y filled in by the funeral director, p Be 25. Was case referred to medical 26. Piece of Daeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending invastigation 1 Netural Injury 1 Yes 2 No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled Ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MINY 2, 2000 OCME 15 30. Nama and eddress of person who completed ceusa of death (Itam 23a) (Type, Print) Ganesh S. Prabhu, M.D., 728 Bel Air Road #136, Bel Air, Maryland 21014 31. Data filed (Month, Dey, Year) 32. Registrer's Signetura

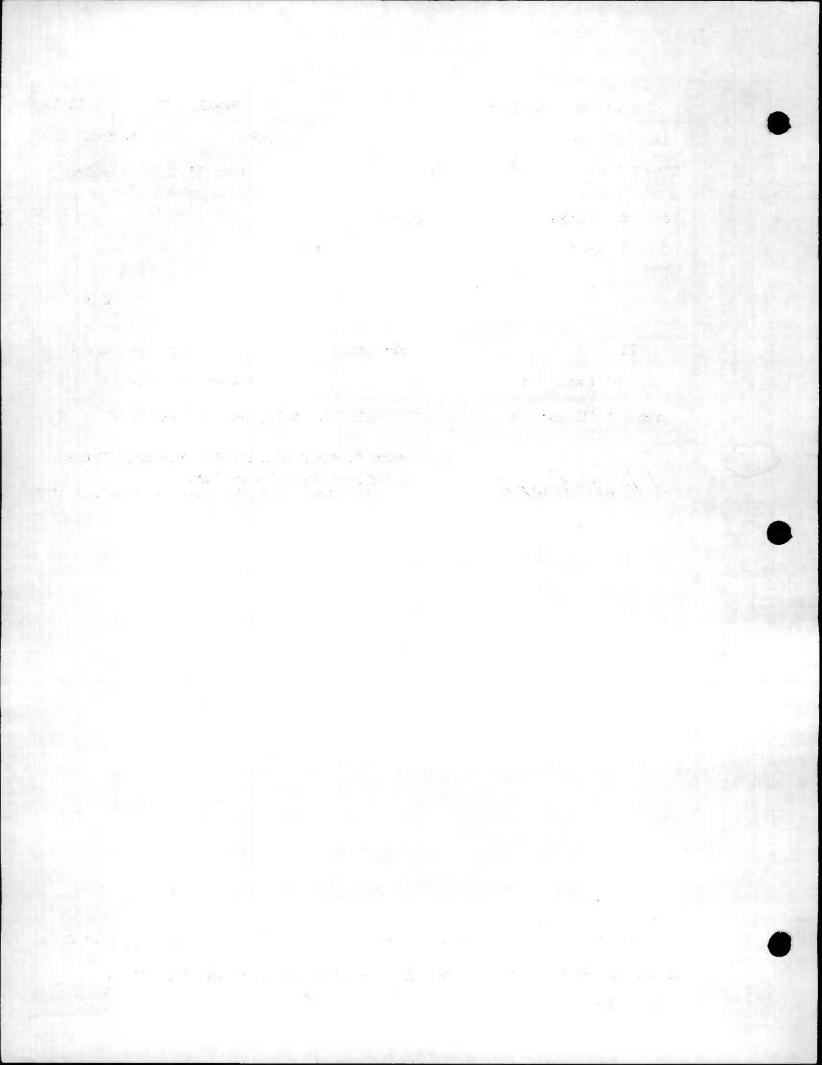
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** : 15 AM Mai 2000 Mary Elinor Slessler /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing & Rehabilatation Center Belcamp If Under 24 Hrs. 1 ff Under 1 Year 8. Date of Birth (Month, Day, Year)

July 27, 1907

8. Birthplace (State or Fore Country)

Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Yrs. Director 166-12-3377 Usual Rasidence of Decedant 10a. Stata 10h County 10c. City. Town or Location 10d. Inside City Limits No Yes 2 No Director Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 230 300 Sunflower Dr. Apt. 273 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yas 20 No If Yas, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, atc. 1 Nevar Married 2 Married 6 1 ☐ Yes 2 ☐ No Specify: Specify: White 3√2 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) College (1-4or 5+) 2 Public Education Educator filled 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and 2 should be ealth and Mental Druscilla (u/k) Fitzpatrick Harrison Levi Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Dennis Schultz / Personal Rep. 1506 Highvue Ct., Forest Hill, MD 21050 Saltimore, 205. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State = 8 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gardens 5-4-00 Bel Air, Maryland 21. Signature of Fundral Sarvice Law 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Entar tha disaasa, or complete shock, or haart feilura. List only had Approximata Interval Between Onset and Death **Physician** duese all Immediate Causa (Final disease or condition rasulting in deeth) /Medical di Examiner Due to (or as a consequence of) Physician/Medical Examiner certificate be executed use as the burial-trant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 68760. that initiated avants resulting in death) Last Dua to (or as a consequence of) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, 5 8 þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas 20 40 1 Yes 20 No Vital after death.

Director: After this certifica 25. Was casa rafarred to medical Be 26. Place of Death (Check only one) Other: 5 Residence 8 Other (Specify) Certification: To of 1 Yas 1 Inpatient 2 ER/Outpatient 3 DOA Mennar of Death 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Division Neturel 2 Accident 5 Pending invastigation 1 Yes 2 No 3 Suicida 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicida pelli 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Cartifiar Medical 29b. Signetura and title of contillion 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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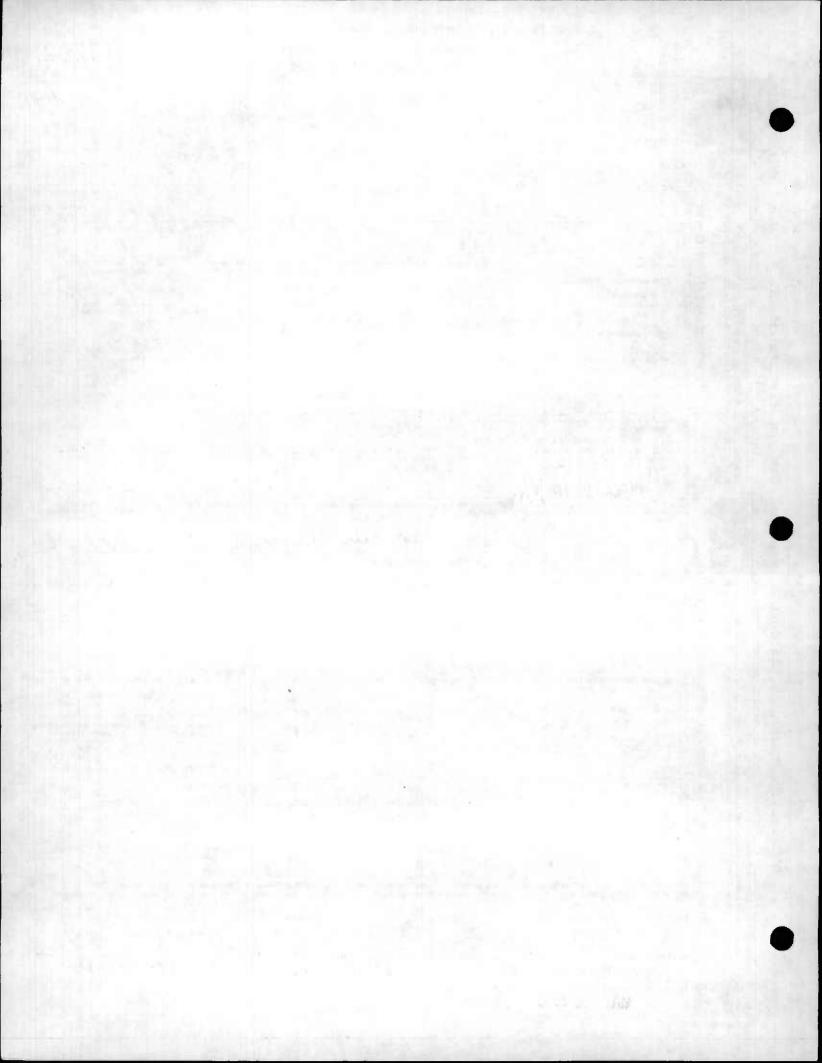
32. Aegistrer's Signatu

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

INDA MEILLE

32. Aggistre's Signature B. Spark

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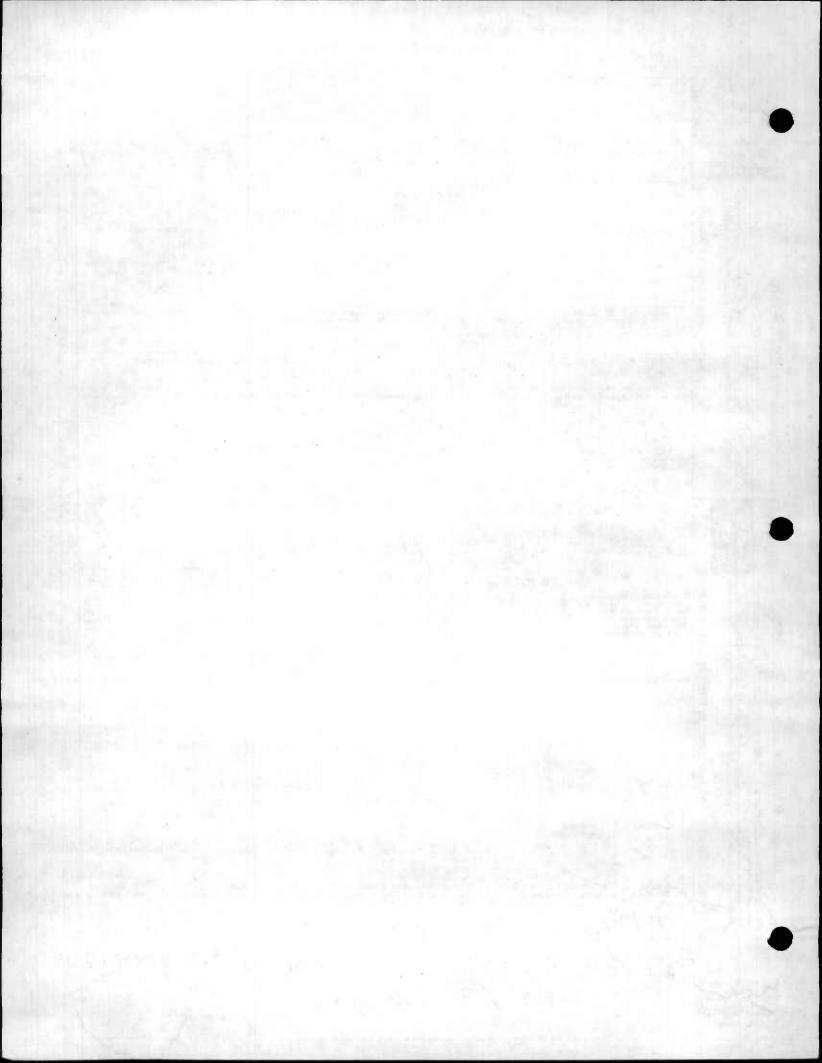
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** ELIZABETH NAOMI SPRINKLE MAY 10, 2000 1:20 PM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2X) F Deys Hours Yrs. 9/13/1917 Director 212-01-8589 Usuel Residence of Decedent MARYLAND the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits worde r 28a-f show 1 Yes 2000 WESTMINSTER Director CARROLL MD. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? e filed within 72 hours efter death with is Hyglene.
other than "natural", or flerme 23a or vent, the Medical Estimate must be a 21157 USA 1034 BREHM RD. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien. Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 27 Merried 21215-0020 Specify: WHITE 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKING 11 Baitimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is merited ofth any Injury or other treumatic avant page. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be MAGGIE BRILHART JOHN STERNER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print)HUSBAND 1034 BREHM RD., WESTMINSTER, MD. 21157 CHARLES H. SPRINKLE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from Stete ST. MARY'S CEMETERY 5/13/00 SILVER RUN, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility FLETCHER FUNERAL HOME 21. Signature of Funeral Service Ligenses 254 E. MAIN ST., WESTMINSTER, MD. 21157 da 23a. Pert1. Enter the disease, or demplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** WENTROULAR FIBRILLATION Immediate Cause (Final disease or condition resulting in death) Jultay /Medical Examiner 3 weaks Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last of Vital Records. P.O. Box 68760. Due to (or es e consequence of): been signed by the should be deteched Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? page 2 s 1 Ves 2 No 1 ☐ Yes 2 ☐ No certificate Attending Physicien: director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 EN/Outpatient 3 DOA this After thi funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death. • Funeral Director: A bletely filled in by the fi death. investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 8 Hospital edical 29e. Certifier 1 Contifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner es stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Dale signed (Month, Day, Year) 29b. Signature and title of certifier Intollede Noelanns 018200 5 12100 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
CHITRACHEDUNAGANNA 700 A poole Rd Wastern weter TD 32. Registrer's Signature State

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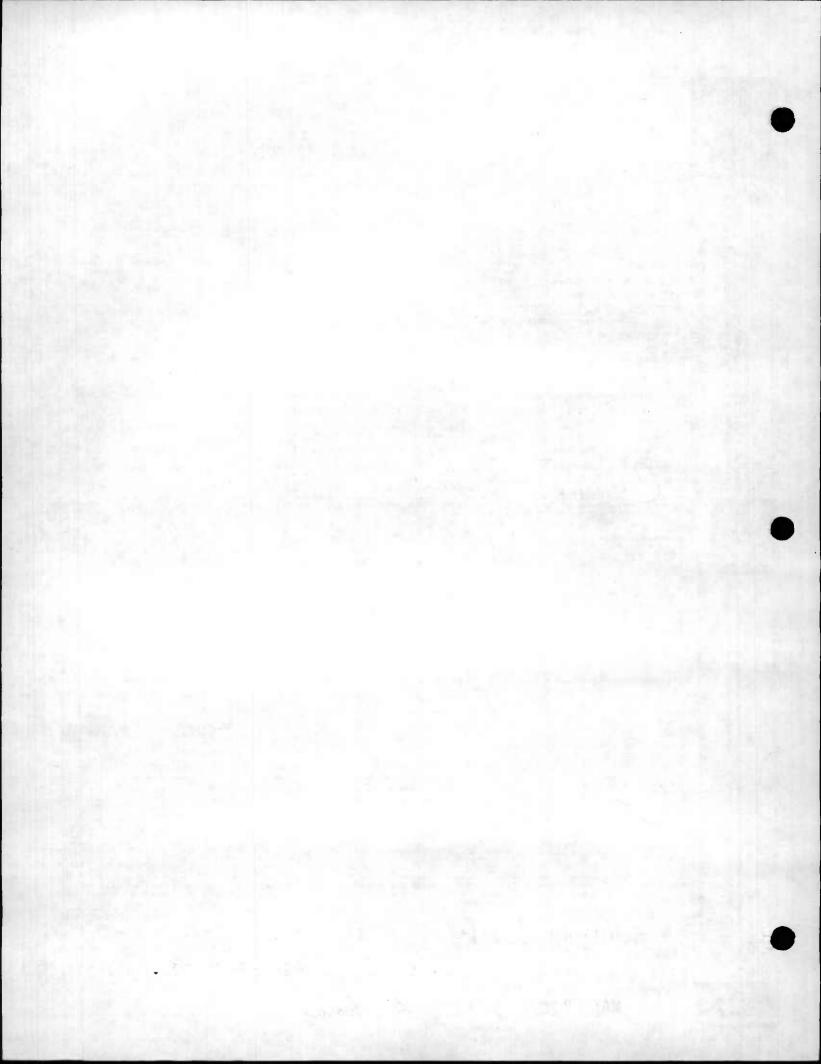
State of Maryland / Department of Health and Mental Hygiene

Output

Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death **Physician** May Beverly Anita Strine 10 2000 1:40 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2252 Baltimore Blvd. Finksburg Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 12 1933 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2⊠ F Yrs. 214-28-1038 Director 66 Maryland Usual Residence of Decedant 10d. Inside City Limits 10a Stete 10b. County 10c. City. Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show say fujury or other traumatic event, the Healts Examinat must be notified an once. 1 ☐ Yas 2 No Director MD Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2252 Baltimore Blvd. 21048 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: White Yas Giva Specify: þ 3 ☐ Widowed 4 ₺ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elemantary/Secondary (0-12) Cotlege (1-4or 5+) a homemaker own home 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Be Lloyd Eugene Gore Thelma Elaine Talbert 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21048 2252 Baltimore Blvd. Finksburg MD Deborah Dayton - daughter 20b. Place of Disposition (Neme of cematery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition May 13 1 XBuriat 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Westminster Cemetery 2000 Westminster, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licensee XVar/ler 310 Church St., New Windsor, MD 23a. Part I. Enter the disease, or complications that caused the leath. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each limit Approximate tntarvat Between Onset and Death **Physician** tmmediate Cause (Finel disaase or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner attending physician end for use as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Dua to (or as a consequenca of) P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Wara eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 1 ☐ Yes 2 ₽ No 1 Yes 2 No certificate Division of Vital or Attending Physician; 25. Was casa rafarred to medical axaminar? Be 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. 1 Natural 5 Panding Injury 1 Yes 2 No invastigetion 2 Accident 6 Could not be detarmined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signatu 29c. License number who complated causa of death (Itam 23a) (Type, Print) 224 WASHINGTON HGTS WESTMINSTER, MD21157 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State MAY 1 2 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 74.05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth 7:15 AM Willard Preston MAY Stumpf 6 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 900 Caton Ave SAINT AGNES HOSPITAL. Baltimore H Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) April 5, 1915 Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sax 7. Age (In yrs. last birthdey) Months 1⊠M 2□ F 85 213-05-9098 Yrs Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 △ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Mamied 2 Married USA 1 Yes 2 No Specify: If Yes, Give Year or Detes Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Technical Assistant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles Stumpf Ada Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Maiden Choice Lane #201, Catonsville, MD 21228 Ava V. Stumpf/Wife 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 5/19/00 Baltimore, Maryland 21. Signature of Eurocal Service Lice 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 460759 23a. Part Enter the disease or compications, has caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic cardiomyopath ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of) that initiated events resulting in death) Lest Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy 2) No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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MD

12

Funeral

Director

5 ne 23a

or items

1 and 2 should be filed v lealth and Mental Hygie im 27 is marked other t ther traumatic event, to

permit. Pages 1 and 2: Department of Health ar Important: If Nem 27 is

21215-0020

Saltimore, Maryland

Physician/Medical Examiner þ Be Completed Medical Certification: To

1 Yes 2 No

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 Netural

2 Accident

3 Suicide

29e. Certifier

4 Homicide

29b. Signature and title of certifier

Kodney

certificate has or Attending Physician: this after deat Director:

within 24 hours aft To the Funeral Di completely filled in ş

State

Registrar DHMH 16 Rev 6/95

S. Iancovici,

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

duconci

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

28c. Injury at Work?

1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

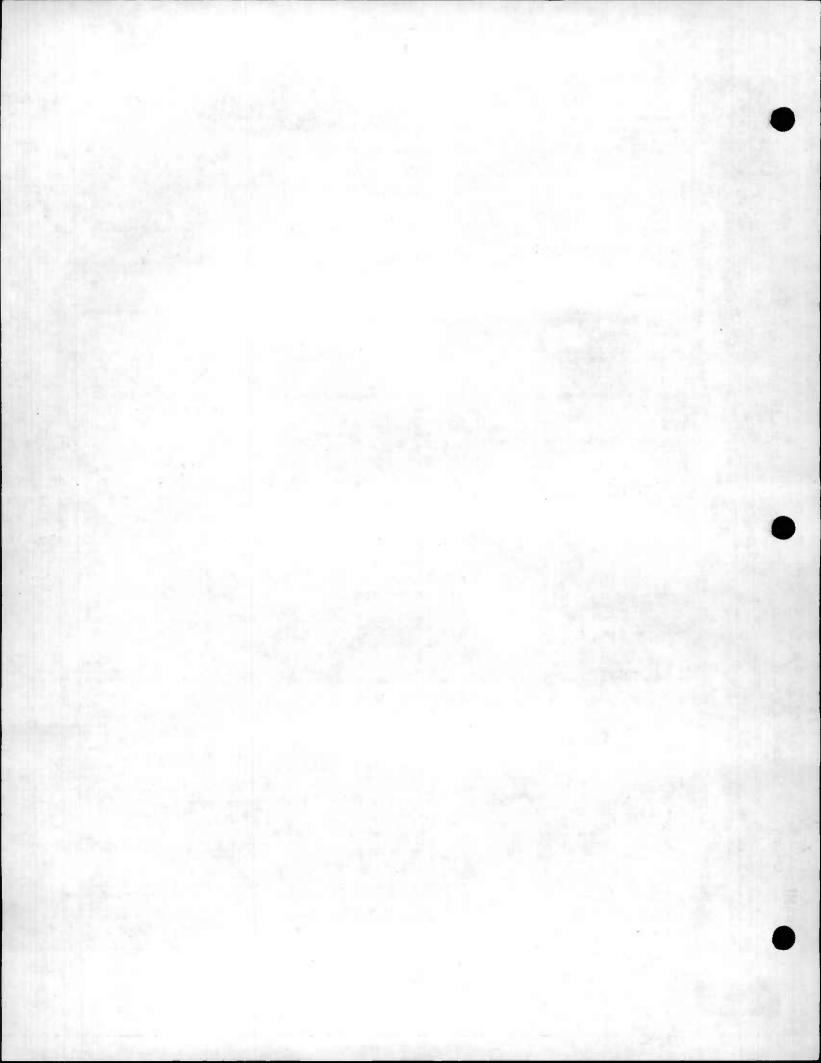
Agnes Hospital Batimore

26. Piace of Death (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

Saint



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:30 AN Dulliva 105510 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Lorien Nursing Home Columbia If Under 24 Hrs. 8. D 8. Date of Birth (Month, Day, Year) 6. 1909 Howard If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 XF Yes Missouri 90 218 10 3312 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haaith and Mental Hygiena. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified as 1 ☐ Yes 2 No MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3702 Takoya Drive 21042 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Mazzone/Friend 3702 Takoya Drive Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-19-2000 Marriottsville, MD 4 Donation 5 Dother (Specify) entombment Crest Lawn Cemetery M01044 22. Name and Address of Facility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** nemus fleematoid anthuite.
Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) /Medical Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last certificata be axec P.O. Box 68760 Physician/Medical tha 88 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No signed by 3 Probably 4 Unknown Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No certificata Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funerel Director: After t 28a. Dete of Injury (Month, Day Year) 5 Pending investigation Aftar 1 Netural 2 ☐ Accident 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

DHMH 16 Rev 6/95

To the Hosp within 24 ho To the Fune complately fi

Medical

(Check only one)

30, Name and address of person who

19

31. Date filed (Month, Day, Year)

ted cause of death (Item 23d) (Type, Print)

32. Register's Signature

Del

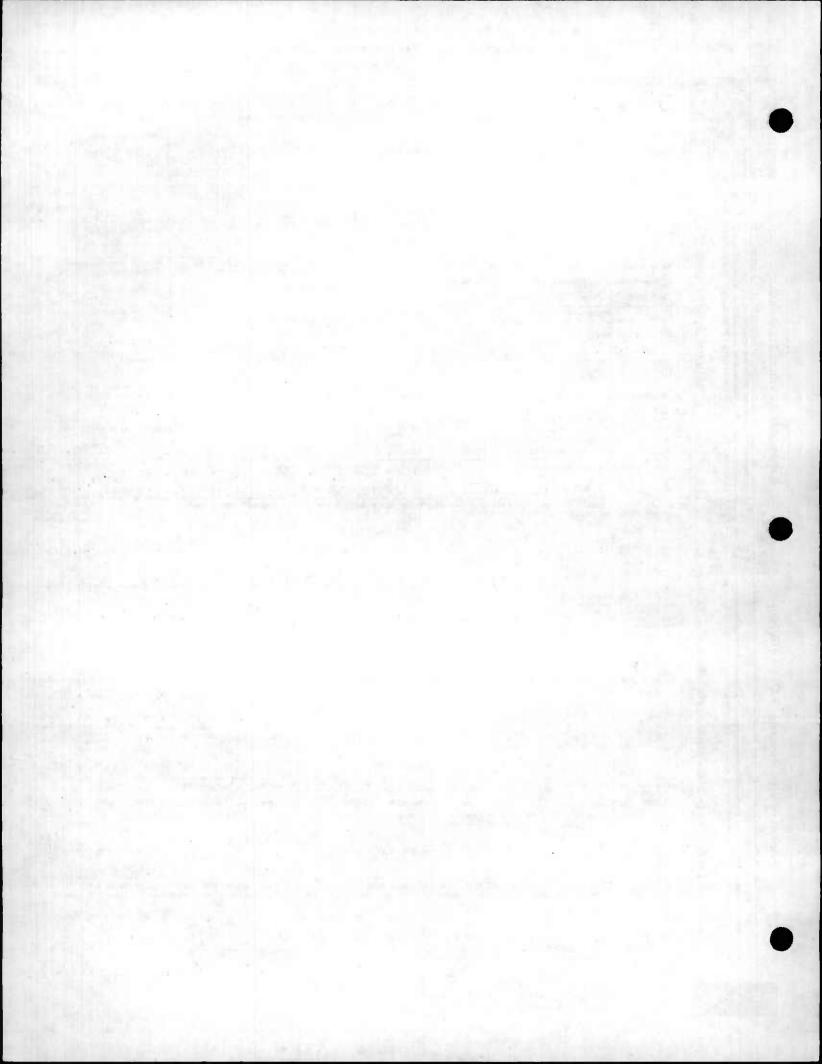
29c. License number

0315

29d. Date signed (Month, Day, Year)

May 18, 2000

Cold Ellett Cel UDZIOP



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year C, CY 2000 Gertie Mae Stillman Am 1/1 4b. City. Town, or Location of Death 4e Facility Name (If not Institution, give street and number) 4c. County of Death Howard Elkridge 6503 Reile Drive If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Xeer) 9. Birthplace (State or Foreign April 19,1930 North Carolina 5. Sociel Security Number Dsys Hours 1□ M 2₽ F 70 Yrs. 217.26.3691 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Elkridge Howard 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 21075 6503 Reile Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indisn, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify. 3 ₩idowed 4 Divorced 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantsry/Secondary (0-12) Coilege (1-4or 5+) Own Home 10 Homemaker 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bertha Prevette Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC60 Box 145 Slanesville, W.V. 25444 Robert Baker/Brother 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20s. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal trom Stata Laurel, Maryland 5/15 Baltimore Washington 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Gary L. Kaufman Funeral Home At Meadowridge Memorial Park, Inc. 7250 Washington Blvd, Elkridge, Maryland 21075 21. Signeture of Funeral Service Licensee 41100843 ha disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, it failure. List only one cause on each lina. Approximate Interval Batwean Onsat and Daath Immediate Cause (Final vopetive disease or condition resulting in death) Cucalize Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Lsst Due to (or as a consequence ot) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown mallitus 24b. Ware autopsy tindings evailable prior to completion of cause ot death? rebrovescular thrombosus 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Dermit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygione. Important: If them 37 is marked other than "natural; or its may injury or other traumatic event, the Medical Examples

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Examiner Physician/Medical þ Be Certification: To

iclan and burial-transit physician s the burial for use funeral After 3

Completed

The law requires that the death certificate be executed Physician: this or Attending L hours after death. uneral Director: After ely filled in by the fun To the Hospital o within 24 hours aff To the Funeral Di completely filled in

edicai

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and placa, and due to the cause(s) and mannar as statad.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only 29b. Signature and tille of certifier mi) OV

5 Pending investigation

6 Could not be

25. Was cese referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 Accidant

4 | Homicide

3 Suicide

29s. Certifier

1 ☐ Inpatient 2 ☐ ER/Outpatient

28b Time of

28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)

29c. License number

3□ DOA

28c. Injury at Work?

26. Placa of Daath (Chack only ona)

Other: 4 Nursing Homa

1 Yes 2 No

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

2 No

5 Residence 6 □Other (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

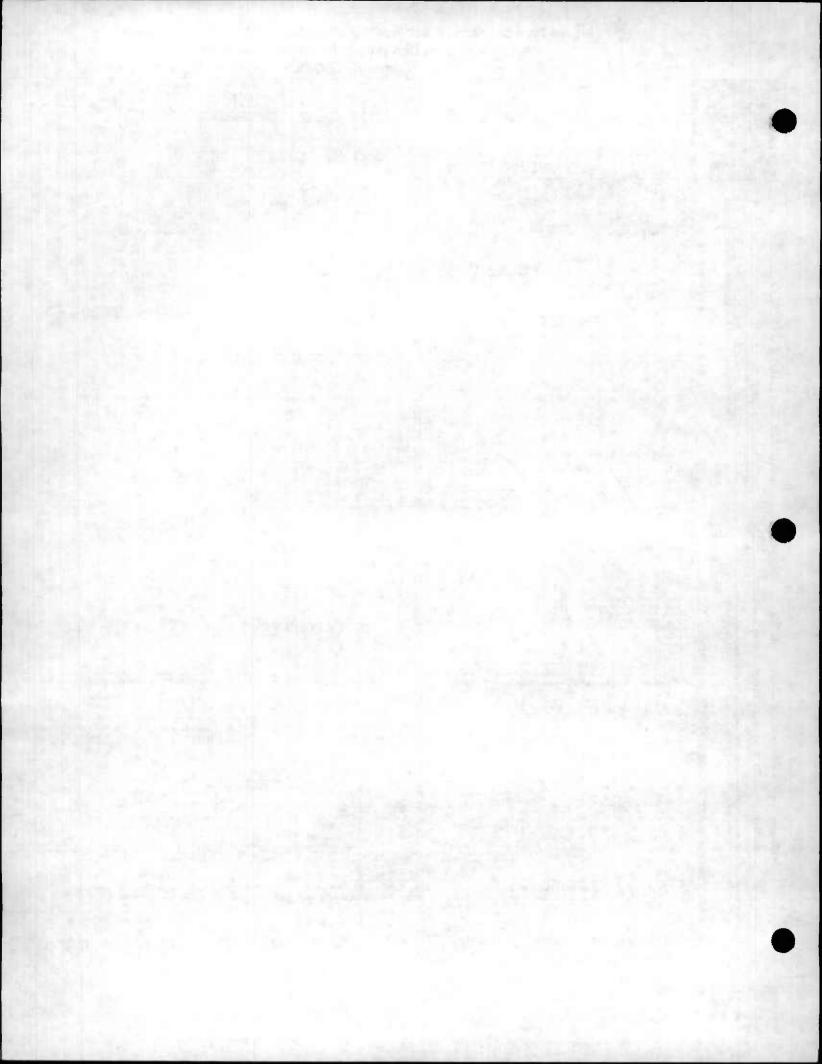
28d. Describe how injury occurred

Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Hospitai:

31. Date filed (Month, Dev. Year) 32. Registuar's Signature 6

28a. Data of Injury (Month, Day Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOHN A. Spindler, Sr. 4e. Fecility Name (If not institution, give street and number) Month 9:30pm MAY 2000 10 /Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Agnes Rehab Center City Ellicott Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Funeral Birthplace (Stete or Foreign Country) 1€M 2□ F Months Days Hours 92 Yrs. Director 213-10-4046 6, 1907 Maryland Usual Residence of Decedent the Maryland a or 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Arbutus 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with permit. Pagas 1 and 2 should be filed within 72 hours after death wi Dapartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a t any Injury or other traumatic event, the Madrell Exercipet must be once. 800 S. Beechfield 21229 Avenue U.S.A. Funeral 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Married 21215-0020 Specify: White 1 Yes 2 XNo Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Worker General Motors Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Alouisous Spindler Katherine Norris 2 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joan Overholtz Daughter 5149 Bie Miller Road Westminister, Maryland 21158 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Memorial Park 5-15-00 Marriottsville, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility Witzke Funeral Homes, Inc.

Witzke Funeral Homes, Inc.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest,

Approximately 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest,

Approximately 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest,

Approximately 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, Witzke Funeral Homes, Inc. Approximete Interval Between Onset and Death **Physician** KESPIRATORY INSUFFICIENCY Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** PLEURAL EFFUSION Physician/Medical Examiner ATERAC The law requires that the death certificeta be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated exacts) Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Denknown of Vital Records, ģ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? certificate has 2 DING 1 Yes 2 1 No or Attending Physician: Be 25. Was case referred to medical examiner? 28. Plece of Death (Check only one) Other: Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral 27. Menner of Death Certification: 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending Investigation Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical (Check only one) 29b. Signature and title of certifiar 29c, License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) PARIL HEIGHTS

AKHANI, 7220 PARIL HEIGHTS

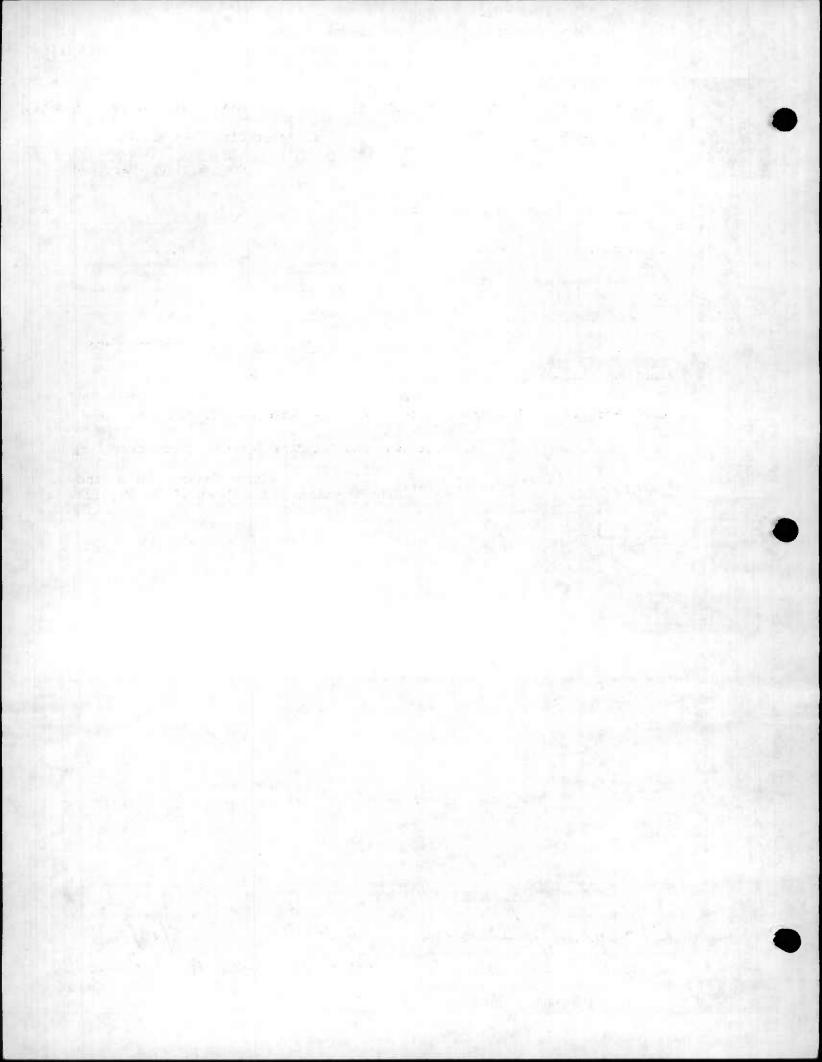
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State

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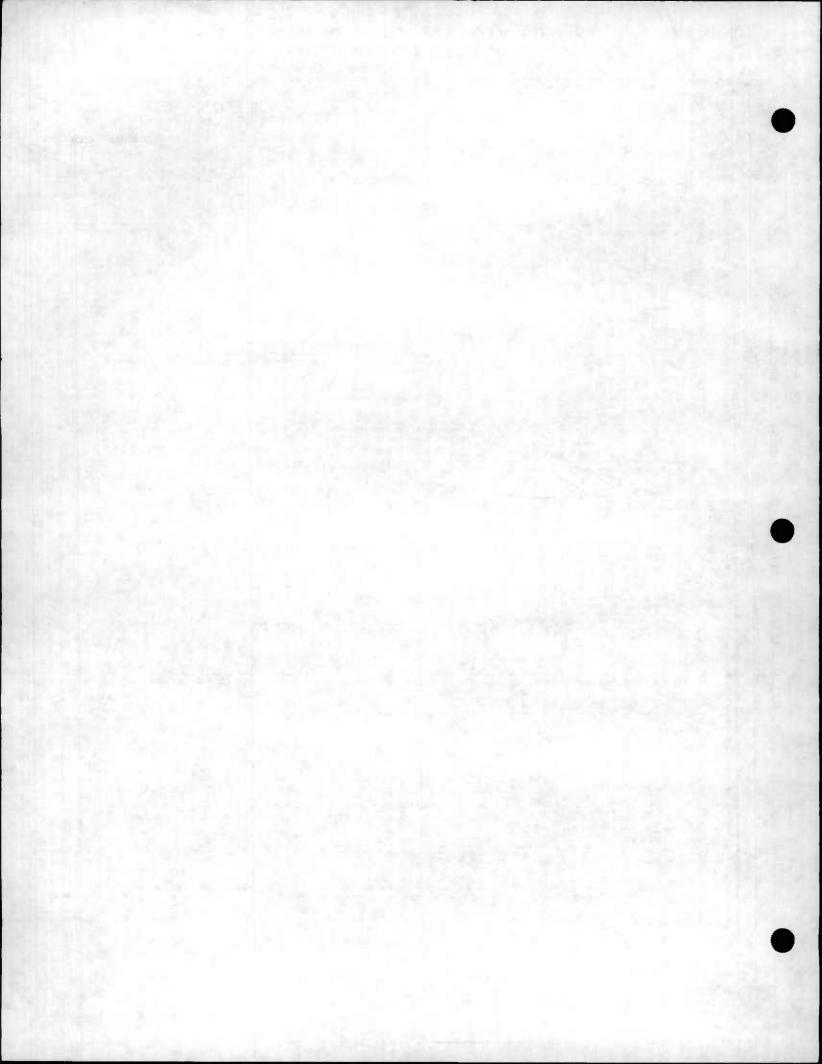


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Funeral Director	5. Social Security Number 218-54-9558		7. M 2□ F	Age (In yrs. 49	lest birthe Yr	Month	er 1 Year s Deys		24 Hrs. Min.	8. Dete of Birth (Month, Dey, June 13	Year) , 1950	9. Birthpl Count Mary]	ece (Stete ry) Land	or Foreign
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Pes 1 Filer or oth	20e. Method of Disposition	tion 2 DB	amount from Cto		Placa of Demetery,	disposition (N	eme of other ple	ice)		Dete	20c. Location -	City or To	wn, Stete	
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Baltimore, I permit. Pages 1 and Department of Health Important: If item 27 any lojury or other thence.	21. Signature of Funerel Se	vice License	0	MOO	770			ess of Fecilit	DOI	naldson e, Laure				
/Medical Examiner Pagician and	Immediete Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	5 .		Due to (or es a co	nsequence o	f): I):	vascu	lar	Diseas	4	1		
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5	30. Name and address of pe	rson who po	mpleted cause of	MATERIAL PROPERTY.	m 23a) (T					Baltimor				1
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Registrar DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 171, 10

			C	ertificate of	f Death	Re	g. No.	17910
Discolators	1. Decedent's Name (First, Middle,	Last)				2. Data of Death		3. Tima of Death
Physician /Medical	Alma	Mae	Ske	elley		May 17	, Day 2000 Ye	11:50pm
Examiner	4e Fecility Nama (If not institution, 12701 Valley		ue		4b. City, Town, or I Cresapt	own		llegany
Funeral Director	218-16-4291	7. Age 1 M 2 DXF	(In yrs. last birtho	Months Day	r If Under 24 Hrs. s Hours Min.	8. Data of Birth Month Day, Dec 10,	Year) 922 9.	Birthpleca (Stete or Foreign Country)
me 23e or 28e-f show rmust be notified at neral Director	Usual Residence of Decedent 10a. Stata 10b. County		10c. City, Town o	r Location				10d. Insida City Limits
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be noted Direct	10e. Street and Number 12701 Valley			10f. Zip Code		10	g. Citizen of Wha	it Country?
ii', or teme 23e or 28e-f ebow regular must be notified at by Funeral Director	11. Maritat Status 1 Never Married 2 Merrie 3 Widowed 4 Divorced	12. Was Decedent Ev	ver in U,S.	13. Was Decedent of If Yas, specify Cu	Hispanic Origin? (S Iban, Maxican, Puert	pecify Yes or No- o Ricen, atc.)	14. Race - /	Amaricen Indian, White, etc.
	15. Decedent's		16a. De	ecedent's Usual Occ	upation	1	6b. Kind of Busin	ass/Industry
	(Specify only highest	grade completed)	(6	ive kind of work don le. DO NOT use reti	e during most of wor	king	OD. TUNG OF EGGIN	add maddiy
omp	Flementary/Secondary (0-12)	College (1-4or 5+		emaker			wn home	2
2 6	17. Father's Nama (First, Middle, L George Campbe				18. Mother's Ner Laura	na (First, Middla, M (nmn)	laidan Sumame)	
any injury or other treumatic anse.	19e. Informant's Neme/Relationsh Ralph T. Skel	o (Type, Print) Ley	195 4	Jailing Address (Street Vall	et and Number or Ru EY V1EW	ral Route Number, Av; Cres	City or Town, Sta aptown ,	MD 21502
redto	husband 20a. Method of Disposition	10-0-1	20b. Place of D	isposition (Nama of	f===1	Data 2	Oc. Location - Cit	y or Town, State
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2	4 Donation 5 Other (Sp. 21. Signature, of Funeral Service L	**	Rocky C		rans Cem Priner			one, MD
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	23a. Part. Enter the disease, or o shack, or heart feilura. List o	omplications that ceused t nly one cause on each line	he death. Do not	enter the mode of d	ying, such as cerdiad	or respiratory arra	st,	Approximata Intervel Batween Onset and Death
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by Physician/		<u>_</u>						
ysic	Part It. Other significant condition	-			given in Part I.	23b. Did tol	bacco use contri	bute to the cause of death?
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leted by	CARSIAC CEREROVAC					040 19/00 00		4b. Were autopsy findings
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Completed	2.0.							of death?
S	CERREROVAS	cular A	ecupans			1 □ Ya	s 2000	1 ☐ Yas 2 ☐ No
e B	25. Was casa referred to medical examiner?					ath (Check only one	a)	
To Be Comp	1 ☐ Yes 2 DeNo		2 ☐ ER/Outp	atient 3LI DOA		loma 5 Desider		Specify)
	27. Nanner of Death 1 SNaturat 5 Pending 2 Accident investigs	28a. Date of tnjury (Month, Day tion	Year) 28b. Tim Inju	ry W	jury at /ork? □ Yes 2 □ No	28d. Describe ho	w injury occurred	
Certification	3 Suicide 6 Could no 4 Homicide detarmin	t be ed 28a. Place of Injur building, etc.	y - At home, farm (Specify)	, street, factory, offic	69	28f. Location (Str City or Town		or Rural Routa Number,
edicai C		Physician: To the best of carniner: On the basis of e	xamination and/o					
Manual Ma	29b. Signature and title of certifier			29c. Lice	nse number	29	d. Data signed (I	Month, Day, Year)
3	> secon			D2.6	5907		May 18	, 2000
U	30. Name and address of person warjit S Sidhi	ho completed cause of deal	ath (ttem 23a) (Ty			mberland	-	
nus"				P WOLDII	roda cu	wcr raii	A 11D 21	.502
State Registrar	MAY 1 8 200	39. Registrar	's Signatura	Sparks	/			

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Date of Death Month 5 **Physician** MARVEL E. SCOTT 2000 12:20 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 106 Ironshire St. Snow Hill Worcester If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) 1/5/1927 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Months Days Hours Yrs. 220-18-6136 73 Director MD Usual Residence of Decedent 10e State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumetic event, the Madical Examinal must be inclined at MD Worcester Snow Hill 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Ironshire St. 21863 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 22 Married WWII 1 Yes 2√ No Specify: Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: if item 27 is marked other than "na any injury or other traumatic event, to a Hada policy. Elementary/Secondery (0-12) Cotlege (1-4or 5+) Assessor State of MD 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Reece M. Scott Margie Mae Smack 19e. Intormant's Name/Relationship (Type, Print) 19b. Malting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Scott/ Wife 106 Ironshire St. Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tXOBurial 2 ☐ Cremation 3 ☐ Removal from Stete Bates Cemetery 5/13/00 Snow Hill, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Burbage Funeral Home 208 W. Federal St. Snow Hill, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, jet only one cause on each line. Approximate Intervet Between Onset and Death tmmediate Ceuse (Finet disease or condition resulting in death) metastatic Due to (or es e consequença of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated exercises) Due to (or as a consequence of) Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24e. Was an autopsy 1 ☐ Yes 2 ☐ No 1□ Yes 2□ No 25. Was case referred to medicat Be 26. Place of Death (Check only one) 1 Yes 2 No

P.O. 1 Records. Division of Vital

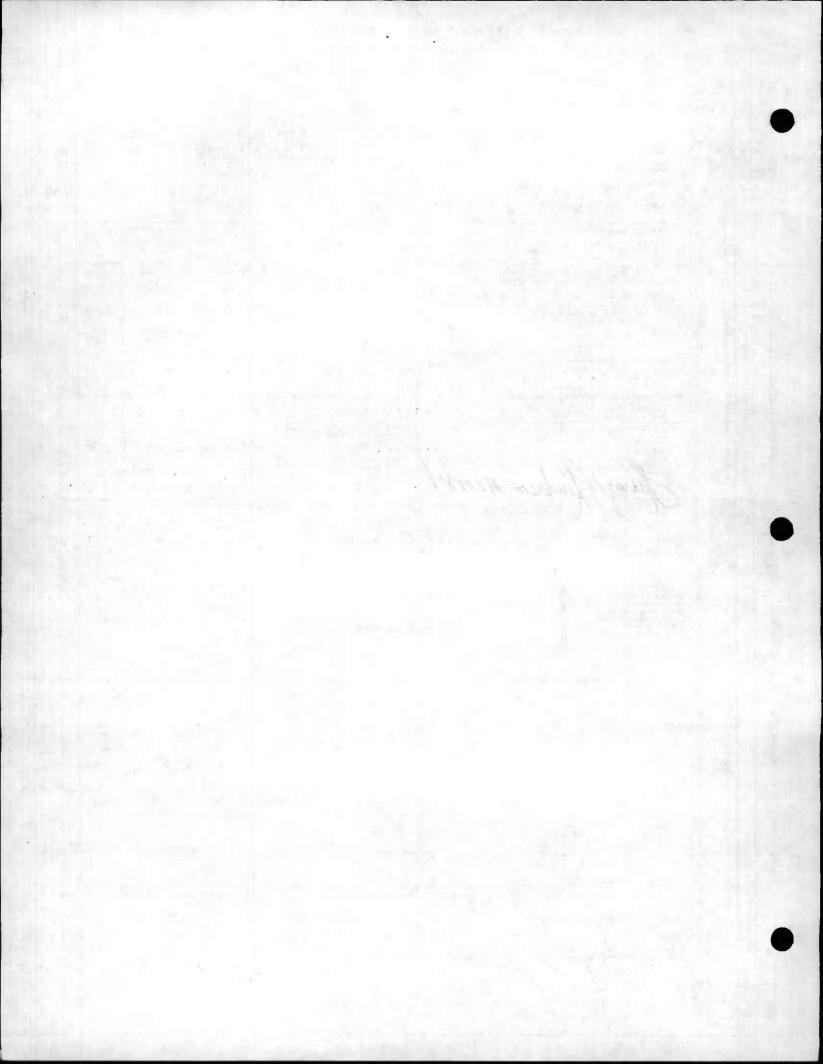
Box 68760.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner ettending physician and for use as the bunal-transit signed by ti certificate To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; p. Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 27. Menner ot Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Netural 5 Pending 1 Yes 2 No 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

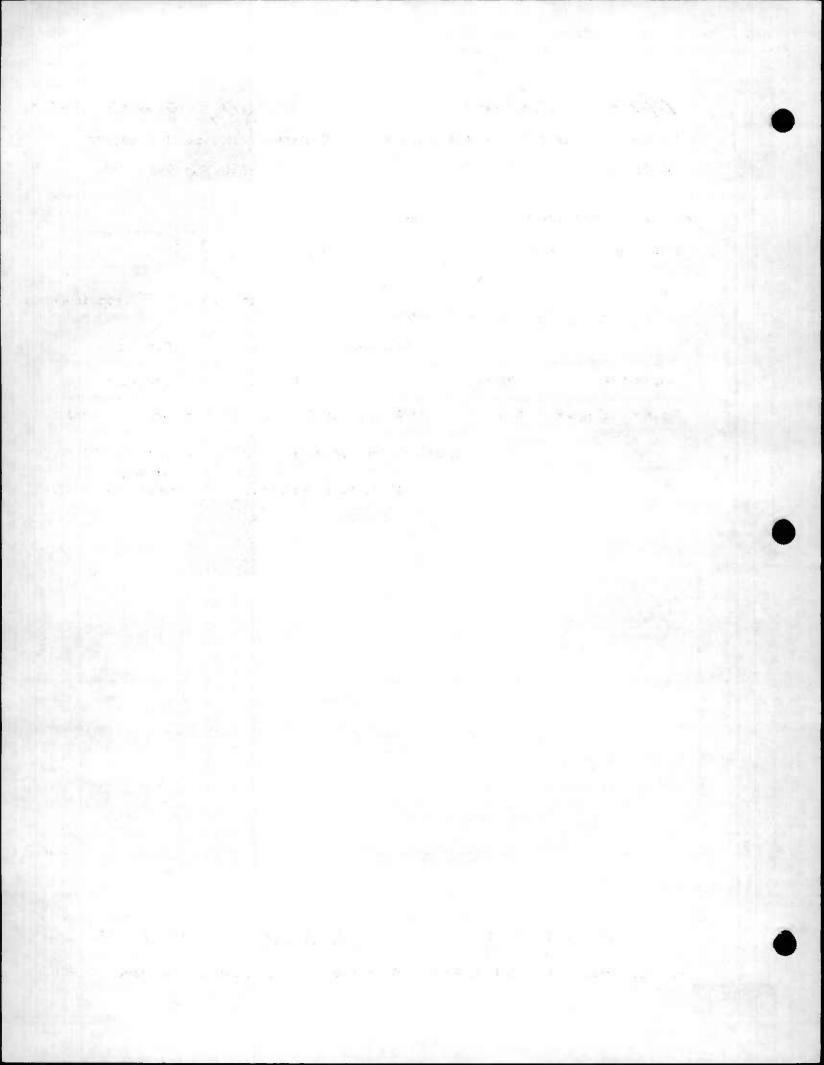
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) manner stated. Medical (Check only 29b. Signalure and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) N.O. May 12, 2000 030690 who completed pause of death-(Item 23a) (Type, Print) rest E. Corroll St. Jolisbury MD 15+ M.O. 31. Date (Month, Day, Year) 32. Registrer's Signeture source Registrar **DHMH 16 Rev 6/95 ORIGINAL**



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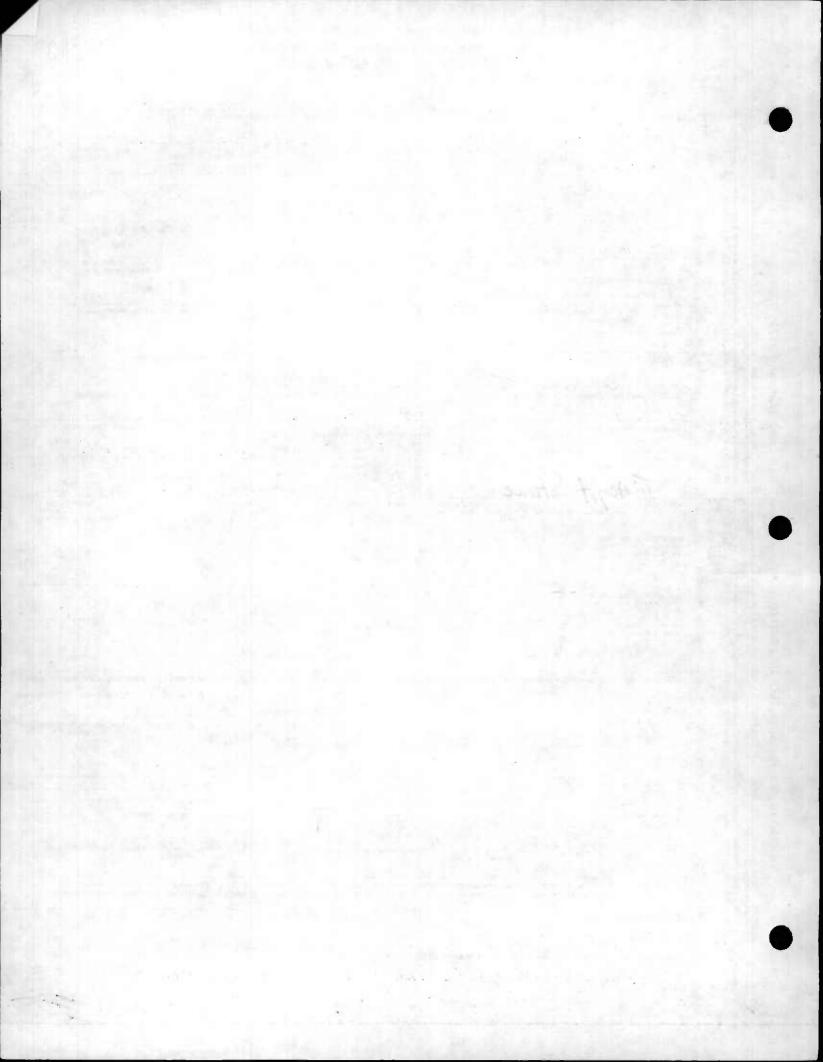
State of Maryland / Department of Health and Mental Hygiene 0 174 12

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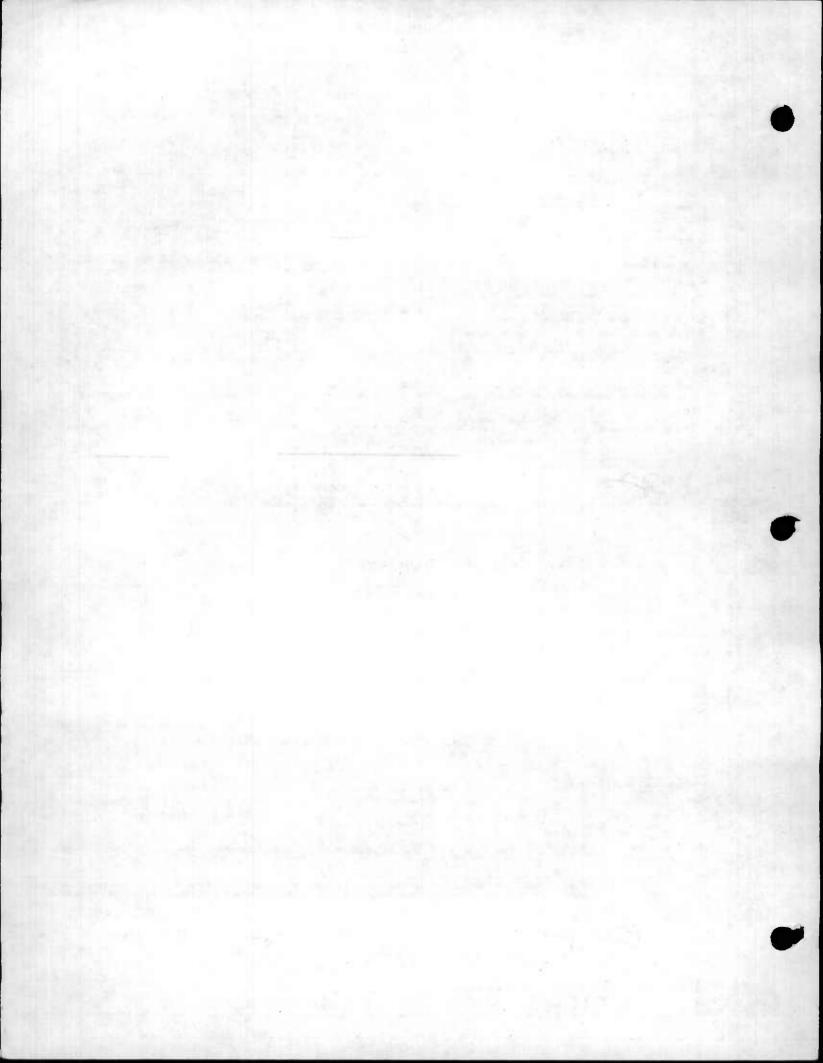
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMENDED ITEMS #10a,b,c,e,f PER INFORMANT G785 /20/00 AH Certificate of Death AMENDED ITEMS #20b, #20c PER FH G785 7/3/00 AH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 2000Yaar DR. IRVING SCHWARTZ MAMonth 12 3:35 PM 4s Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY
If Under 24 Hrs. 8. Date of Birth
Hours Min. AUM 1993 Pay 1997 1919 Country NY MONTGOMERY If Under 1 Year 7. Age (tn yrs. last birthday) Funeral 5.79-16-2684 1₩ M 2□ F Days Yes Director Usual Residence of Decedent the Marylend 10s. State 10b. County PALM BEACH 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow HD FLORIDA MONTGOMERY BETHESDA 1 No Yes 2 No DELRAY BEACH Director 10e. Street and Number 5450 WHITLEY PARK TERRACE #513-10f. Zip Code 20814 10g. Citizen of What Country? UNITED STATES 6 Examiner must be permit. Peges 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is married other than "natural", or items 23a early Injury or other traumatic event, the Medical Examinat musts page. 5780 PRINCESS PALM COURT APT. D 33484 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 (⅓ Yes 2 □ No NAVY
If Yes, Give
Year or Dates: 1943–1946 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 □ Never Married 2 M Married Baltimore, Maryland 21215-0020 WHITE 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
DENTIA SONOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) 5+ College (1-4or 5+) MEDICAL 17. Father's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumema) Be 10 RACHEL NATHANSON MAX SCHWARTZ 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) SHANNA SCHWARTZ (WIFE) 5450 WHITLEY PARK TERRACE #513 BETHESDA MD 20814 20b. Place of Disposition (Name of cametery, cremetory or other place)
KING DAVID MEM. GARDENS 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State FALLS CHURCH, VA 4 ☐ Donation 5 ☐ Other (Specify) WORLDAND GARANENS 5/14/00 -ONLEY-MD 21. Signature of Funeral Service Licenses DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE MD 20852 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical RESPIRATORY FAILURE Examiner PROBABLE ASPIRATION Examiner The lew requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last ALZHEIMER S DISEASE P.O. Box 68760, Physician/Medical the state of Due to (or as e consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 HODGKINS LYMPHOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ped ed b Records, à 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? Deen pege 2 1 Yes 2 No 1 Yes 2 No certificata Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

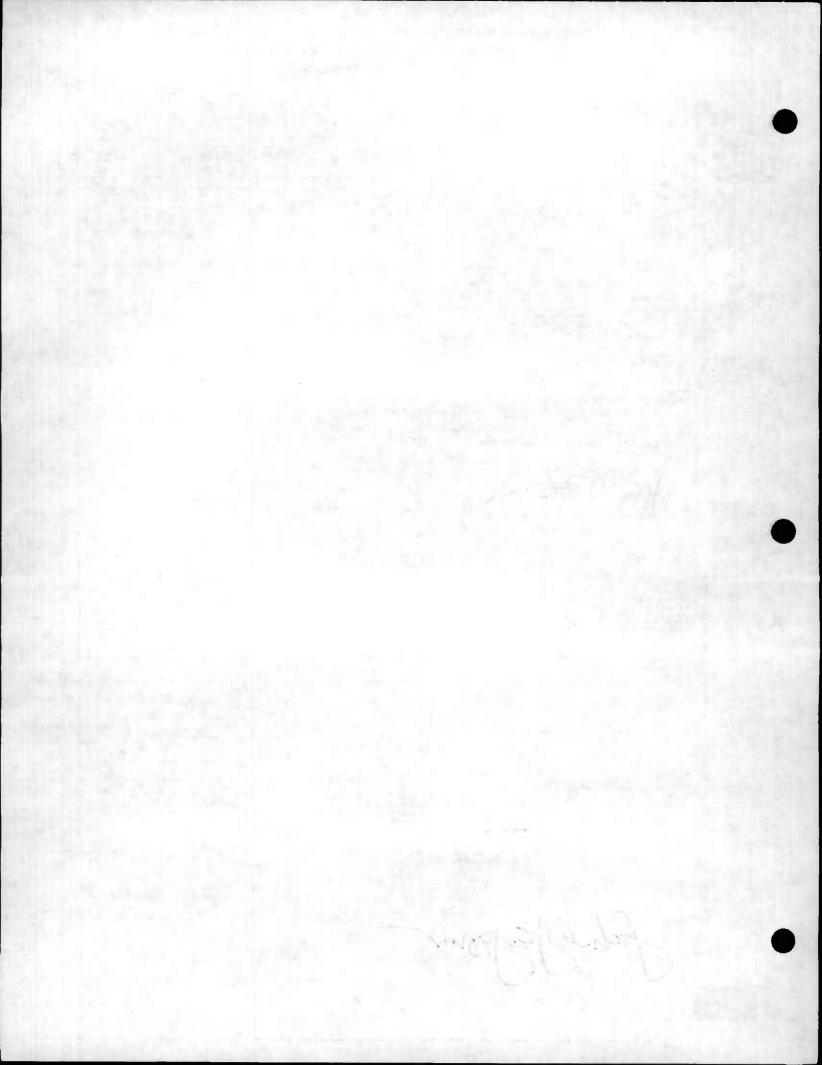
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) physician. 110054566, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUNITHA BHOGAVILLI 8609 2ND AVENUE SUITE 404 B SILVER SPRING MD 20901 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State 2000 MAY 15 souls Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 17415

				Cer	tificate	of	Death			Reg. No.			
D	1. Decedent's Name (First, Middle, Last)								2. Date of Death Month Day Year			3. Time of Death	me of Death
Physician /Medical	Anna Rickards	Sensenig						V	May 1		T Gui	7:30 AM	1
Examiner	4a Facility Name (If not institution, g	give street and numb	ber)		743	4	4b. City, To	wn, or L	ocation of Deat	th 4c. County	of Deeth		
	11609 Milbern Dr	rive					Potom			Mont			
eral	5. Social Security Number 197–26–5318	Sex 7	. Age (In yrs. last 91		If Under 1 Months	Year	If Under	24 Hrs. Min.	8. Date of Bi	rth ay, Year)	9. Birtho	place (Stete or Fore	ign
or		10 W 2001	91	Yrs.					January	2, 1909	Pennsy	Ívania	
	Usuel Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	cation						1	Od. fnside City Lim	nits
6	Maryland Montgom	erv	Potor	mac								1 ☐ Yes 2 🖏	
Directo	10e. Street and Number	ııac	10f. Zip C	Code				10g. Citizen of V	Vhet Cour	ntrv?			
	11609 Milbern Dr		20854					United State					
Funeral	11, Marital Status	12. Wes Deced	12. Wes Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (Spe				ecify Yes or No						
	1 ☐ Never Married 2 ☐ Married	d 1 ☐ Yes 2	1 ☐ Yes 2 K No						Blac	k, White,	etc.		
þ	3 Midowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:	1	☐ Yes 2	₪ No	Specify:			Specify	. W	hite	
Be Completed	15. Decedent's (Specify only highest)	Education	1	6a. Deced	ent's Usual kind of work	Occup	ation	t of work	ina	16b. Kind of Bu	siness/In	dustry	00
nple	Elementary/Secondary (0-12)	College (1-4		life. D	OO NOT use	retired	d)						
20	MINES ELECTION	4]	Busine	ess Of	ffic	ce Ass	sist	ant	Private	Sch	1001	
Be (17. Father's Neme (First, Middle, La						18. Mothe	r's Nam	e (First, Middle	, Maiden Sumam	Θ)		
2	Archie Theodore	Rickards					Marg	gare	t Ritch	nie			
	19e. Informent's Neme/Relationship									ber, City or Town,			
	Barton Sensenig/	Son					Drive	2, P		Marylar			
	20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from St	ate Val	etery, crem	sition (Name natory or oth	her plac	ce)	I	May 18,	King of			
	4 ☐ Donation 5 ☐ Other (Spe	Memo	orial Gardens				2000 Pennsylvania bert A. Pumphrey Funeral Hor						
	21. Signature of Funeral Service Lic	censee										neral Hom nsin Aven	
	Afra 12 To	tund	M00689		Beth	esd	a, Ma	rvla	nd 2081	14-3501	13001	ISIII AVEI	nue,
	23a Fart Endr the disease, or co	omplications that cause on each	used the death. I ch line.	Do not ente	er the mode	of dyin	ng, such as	cerdiac	or respiratory a	arrest,		Approximate Interval Between	
											Onset and Death		
	Immediate Cause (Final disease or condition a Acute Embolic Stroke resulting in death)									i	4 Days		
	resulting in death)		Due to (or as	s a consequ	uence of):								
ine		b					7.40		- 10				
Examine	Sequentially list conditions, if any, leading to immediate		Due to (or as	s a consequ	uence of):								
8	Cause (Disease or Injury										1		
Medical	resulting in death) Last		Due to (or as	a consequ	uence of):						1		
M	d												
Cia	D. 411 Other - 4-144			- 1- 11	4.4		- to Do 44		One Did	1 4 a b a a a a a a a a a a a a a a a a a	- 4 - 1 - 1 - 1	a the same of day	AL 2
Physician	Part II. Other significant conditions	s contributing to dea	in out not resultir	ig in the un	idenying cei	use giv	ren in Pert I	•		Yes 2□ No	3 Pro	o the cause of dea bably 410 Unkn	
by Pt									1	1188 ZU NO	3 _ P10	Service AVI OUKL	I-OWIT
										s an autopsy		ere autopsy finding	gs
Completed									perf	ormed?	CO	railable prior to empletion of ceuse death?	
dmc									10	Yes 2 No	- 11-1	□Yes 2□ No	
	25. Was case referred to medical	_					20 Di	-(D			,,,	LI 162 2LI NO	
o Be	examiner?	Hospital:	nations OFF	1/Outootinal	• • • • • • • • • • • • • • • • • • •	Oth	.00		th (Check only		/Ci	4.1	
. To	27. Menner of Deeth	28a. Date of		ent 2 ER/Outpatient 3 DOA 4 Nursing H					Home 5 B Residence 6 □Other (Specify) 28d. Describe how injury occurred				
to	1 Natural 5 Pending investigat	(Month,	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No				No						
fica	3 Suicide 6 Could no	t be 28e. Piece o	28e. Plece of Injury - At home, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number,					
Certification:	4 Homicide determined determined building, etc. (Specify)						City or Town, Stete)						
	29e. Certifier 1 Certifying	Physician: To the b	est of my knowle	dge, deeth	occurred et	t the tir	me, dete en	d place.	and due to the	cause(s) and ma	nner es s	stated.	
edical		aminer: On the bas and manne	is of examinetion										
×	29b. Signature and title of certifier	111-			29c.	Licens	ense number 29d. Date sign			29d. Date signe	d (Month,	Day, Year)	
1	1 talul	STEN	mag			D3	3554		18	May 15,	200	0	
)	30. Name and address of person with	no completed cause	of death (Item 23	3a) (Type, F	Print)					1109 13,	200		
	John E. Yerg, I	/ 1				ρ.	N.W	Was	shington	n, D.C.	2001	5-2008	
State	31. Date filed (Month, Day, Year)		istrar's Signature		-II-CIIU	-,		11613	Ing co	, 0.0.	2001,	2770	
* State Registrar	MAY 17	2000	anna	4	1	0. 4	1.						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 7416 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Month **Physician** Arthur E. Shaw May 13, 2000 1:15 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing & Wellness Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | September 22,1912 9. Birthplece (Stete or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1월M 2□F 87 058-10-1527 Yrs. **Director Uaual Residence of Decedent** the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d, Inside City Limits r 28a-f show a notified at show 1 ☐ Yes 2 ☒ No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours attac death with 1 Department of Health and Mental Hydjans.

Department of Health and Mental Hydjans.

Department 12 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner mail be a 5808 Warwick Place 20815 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yea or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ğ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Retail Products Distributor 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Schornstein Augusta Kamerman 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Eugene Tillman/ Nephew 5808 Warwick Place, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, State May 14, 1 ☐ Burial 2 In Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) ery Crematorium, Inc. | 2000 | Bethesda, Maryland | 22. Nama and Address of Facilin Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Montgomery Crematorium, Inc. ature of Funeral Serv M00689 Bethesda, Maryland 20814-3501 Part II Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, the failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Myocardial Infarction disease or condition resulting in death) Immediate Examiner Due to (or as e consequence of): Examiner Arteriosclerotic Cardiovascular Disease physician and the buriel-transit certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. edical Due to (or as a consequence of): attending p Physician/M P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the th signed by t 1 Yes 2 No 3 Probably 4X Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? should ! Completed 24a. Wes en autopsy performed? pege 2 386 certificate 1 ☐ Yes 2X No 1 ☐ Yas 2 ☐ No Division of Vitai funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4⊠ Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yea 2 No 2 this 28a. Date of tnjury (Month, Day Year) 27 Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After al or Attanding P s after death. If Director: After ed in by the funer 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) illed in by 4 ☐ Homicide To the Hospital or within 24 hours aff To the Funerel DI completaly filled in Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature age title of D01120 May 14, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

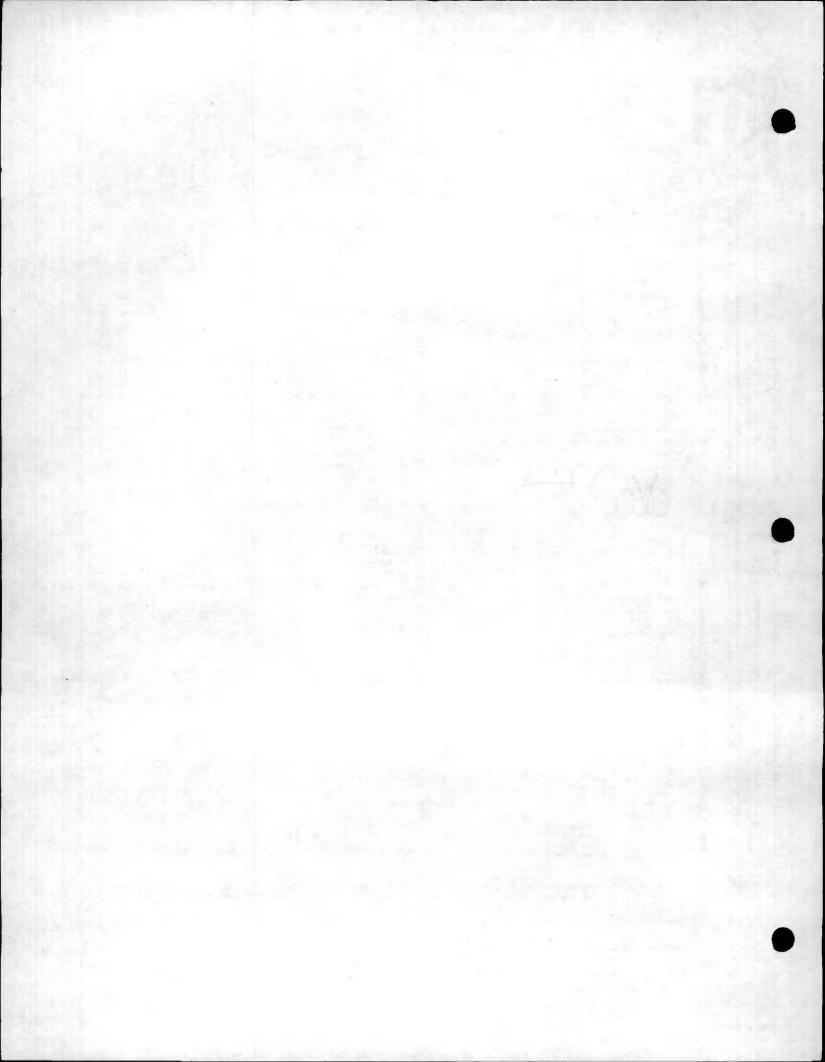
31. Date filed (Month, Day, Year)

MAY 15 2000

souks

Walter E. Goozh, M.D., 1299 Lamberton Drive, Silver Spring, MD 20902

32. Registrar's Signature



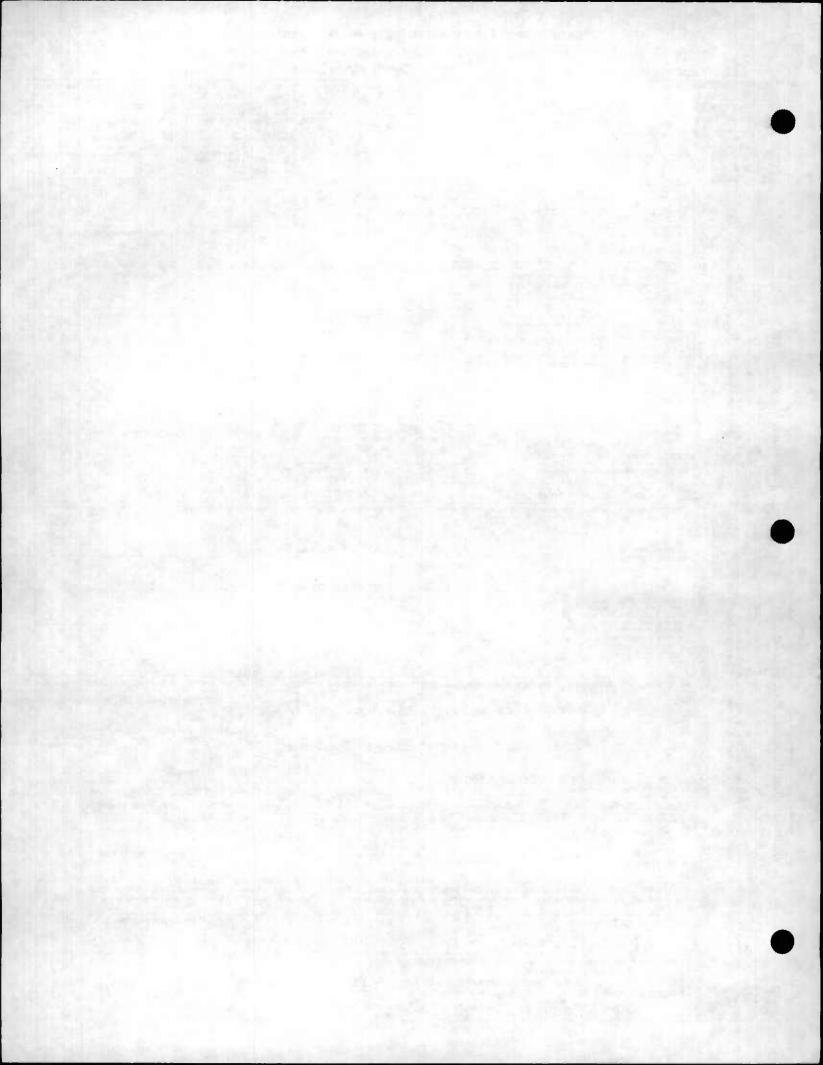
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#2 perPHYG785 7/25/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 12:25 pm Sharon A. Shenton 05 /Medical 4a Facility Nama (It not institution, give street end number)
University of Mary land Medical Center 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltmare Bulhmore Hours Min. 8. Date of Birth (Month, Pay, Year) 49 7. Age (In yrs. lest birthday) 51 Yrs. If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Security Number **Funeral** 1□ M 2X F 203-38-0452 Pennsylvania Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hypiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any liury or other treumatic avent, the Healts Emerical must be notified a DBG. or 28a-f show Delaware Sussex Ellendale 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 19941 United States 299 Railroad Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LPN Nursing Home 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Romaine Yocum Paul Alton Ranck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Sandy Doane/ Sister 829 High St. Williamsport, PA Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Chesapeake Crematory5/13/00 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee CAFA Stephen D. Lohrmann P.A. C. Hardesty 8717 Green Pastures Dr. Balto. MD 21286 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final Sexphi' Shock Due to (or as e consequenca of): disaasa or condition resulting in death) Examiner Physician/Medical Examiner Coloutaneas The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): and physician s the burial +mmunusuppression Due to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert f. P.0. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Insulin' Dependent Diabetes Mellins by 24b. Wara autopsy findings evaileble prior to 24a. Was an autopsy performed? Medical Certification: To Be Completed Panereas trunsplant, Then trunsplant completion of cause of death? After this certificate has 25. Was case referred to medicel axaminar? 1□ Yes 2□No 1 ☐ Yes 2 ☐ No after death.

Director: After this certification of in by the funeral director, 26. Place of Death (Check only one) Hospital: 1 Prinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidenca 8 Other (Specify) 1 Yes 2 No 28a. Date of tnjury (Month, Dey Year) 27. Mannar of Death 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred or Attending t Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28a. Place of fnjury - At home, farm, straet, factory, offica building, atc. (Specify) 4 Homicida

Box 68760. Division of Vital Records,

filled in by To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha causa(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end fittle of certifier Jebu Dnaline mo 05/11/00 12422 30. Name end addrass of person who completed cause of death (Itam 23a) (Type, Print) Debrat. malone Sout Green Sheet Bulhnure, manyland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2000 oaks neva

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3 Time of Death Dey Month Yeer JANAK DULARIT SINGH 1010 17 2006 MAY 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death 3112 Johnings ROAD MOSBOMEN MARGHOW If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. lest birthday) Oct 1, 1930 5. Social Security Number Birthpiece (State or Foreign Country) 1 M 2 F Deys 69 Vre 094-80-4110 Guyana Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 27 No New York Queens South Ozone Park 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 11420 11506 111 Avenue Guvana 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Bleck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: Asian 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Unknown Ramkhelawan Sookwaria Unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Shivdatt D. Singh/ Son 11506 111 Avenue, South Ozone Park, NY 11420 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremetion 3 X Removel from State 5/21/00 Pinelawns, NY 4 ☐ Donetion 5 ☐ Other (Specify) Elcock Funeral Home 22. Name end Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funerei Servica Licensee 500 University Blvd., W, Silver Spring, MD 2090 23a. Perf. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Finel Premonta diseese or condition resulting in death) Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieled events resulting in deeth) Last Due to (or es a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably Onknown 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24e. Wes en eutopsy 2040 1 □ Yes 2 No 1 🗆 Yes 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred

Examiner Examiner The law requires that the deeth certificate be executed attending physicien end for use es the bunal-tran P.O. Box 68760, Physician/Medical signed by the a Division of Vital Records, by Completed peen is certificate has t director, page 2 s al or Attending Physician: The safter death.

I Director: After this certificet of in by the funeral director, pa

Physician /Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mentel Hygiene.
Important: If Nem 27 is marked other then "natural", or itema 23a or 28a-f show any Injury or other traumatic event, if a Mostan Examiner must be notified at

Baltimore, Maryland 21215-0020

27. Manner of Deeth 1 Naturel 2 ☐ Accident

29a. Certifier

Be

2

Certification:

Medical

25. Wes case referred to medical exeminer?

> 6 Could not be determined 3 Sulcide 4 D Homicide

5 Pending investigation

28b. Time of

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stele)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pieca, end due to the cause(s) and menner as stated.

2 Médical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end menner steted. (Check only one) 29b. Signature and title of certifier

(OME ua.

29c. License number

29d. Dete signed (Month, Dey, Year) may 17, 2000

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) CALL I. MARGOUS IMO

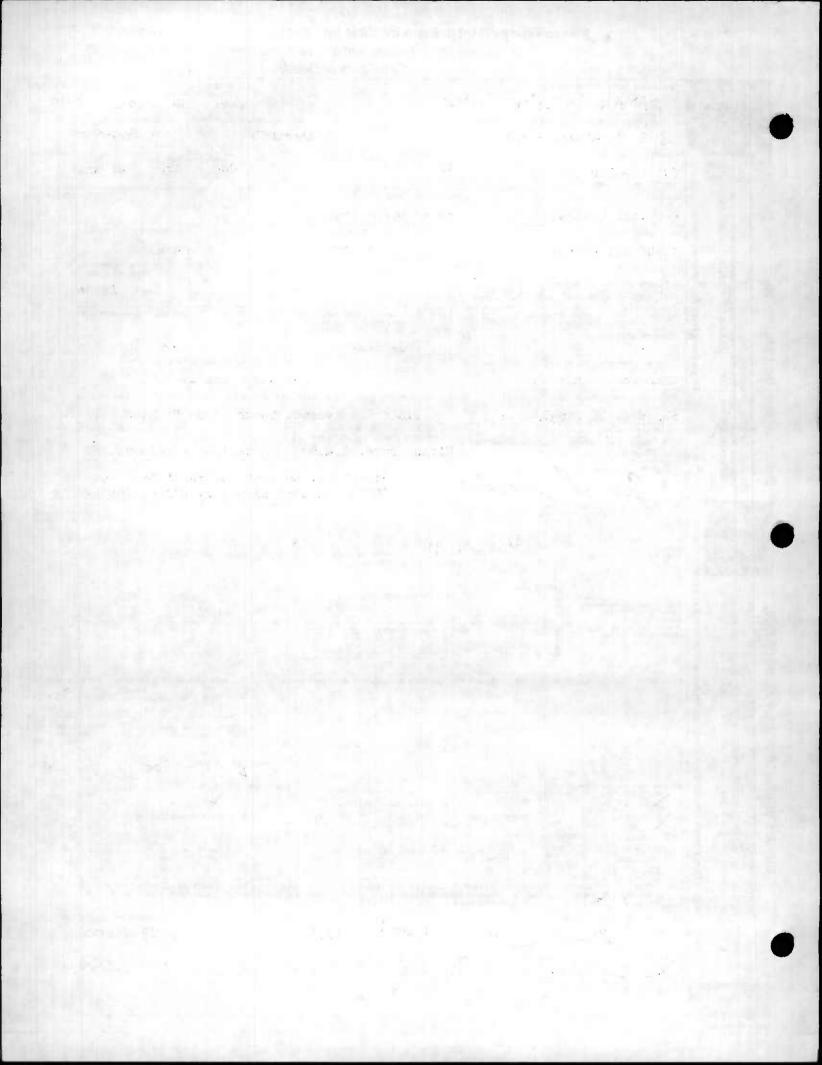
31. Dete filed (Month, Dey, Year) 2000 19

32. Registrer's Signeture

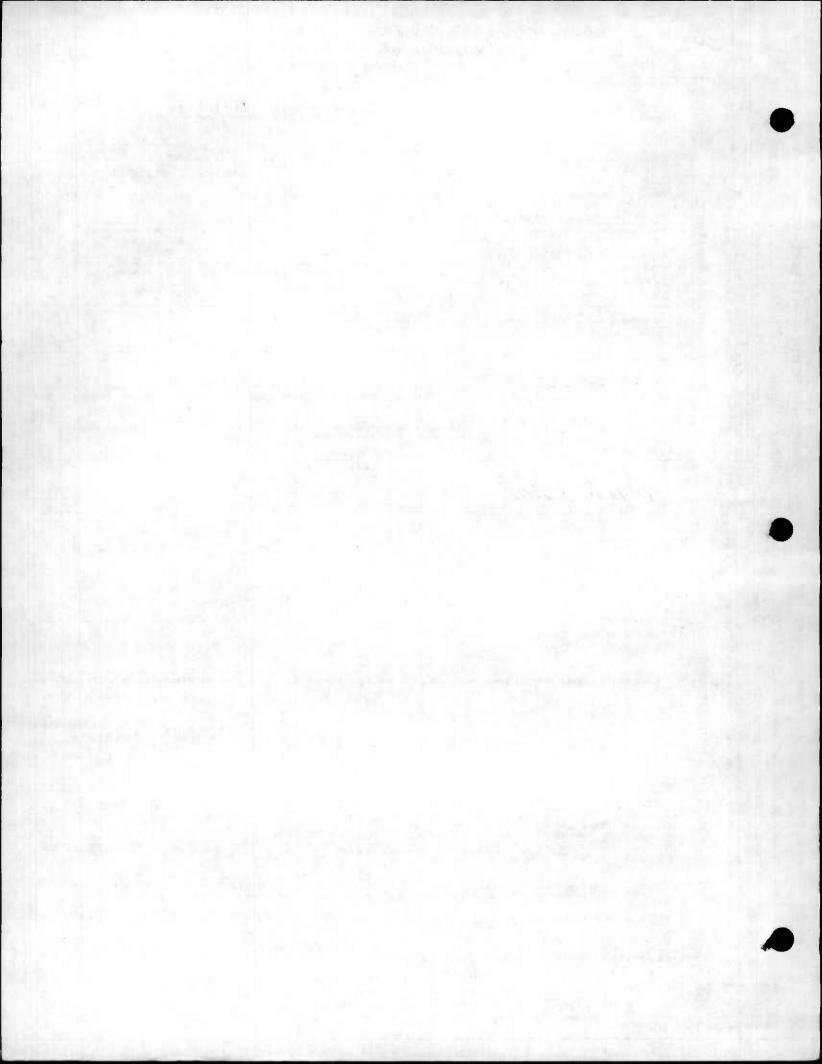
11125 Procesius PIKE, ROCKINE, MO

State Registrar

To the Hospital or within 24 hours aft To the Funeral Di completely filled in



		State of Ma		partment of e <i>rtificate of</i>	Health and M	ental Hy	giene ()	17419
				enilicate of	Death		Reg. No.	
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	awrence S					may	10 2	000 2:11 PM
4a Facility Name (If	not institution, give	street and number)			4b. City, Town, or Lo	cation of Deat	4c. County of	of Death
		y Hospita			Lanham		Prince	George's
5. Sociel Security Nu	16	7. Age	(In yrs. last birthda	Months Day		8. Dete of Bir (Month, De	th ly, Year)	Birthplece (State or Foreign Country)
220-46-9	031	2 m 201	53 Yrs.			Aug. 2,	1946	Maryland
Usuel Residence of I	10b. County		10c. City, Town or	Location				10d. Insida City Limits
			roc. Ony, rown or	Cocation				1 ☐ Yes 2 ☑ No
Maryland		eorge's	Gree	nbelt				
10e. Street and Num	ber			10f. Zip Code			10g. Citizen of W	hat Country?
8447 Gree				20770			USA	
1. Merital Stetus		12. Wes Decedent E Armed Forces?	Ever in U,S. 13	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spe ban, Mexican, Puerto	cify Yes or No Rican, etc.)	- 14. Race Black	- American Indien, c, White, etc.
1 Never Merrie		1√DYes 2 N If Yes, Give	lo	1 ☐ Yes 2 ☑ No			Specify:	
3 □ Widowed 4		Year or Detes:			THE BANK			White
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	F	1	Insur	ance Sale	es Manager	-	Insuran	
17. Fether's Name (F	First, Middle, Last)				18. Mother's Neme	(First, Middle	, Meiden Sumeme	9)
Joseph A	llen Smit	:h	1.		Pearl K			
19e. Informent's Ner	ne/Relationship (Ty	rpe, Print)	19b. Ma	illing Address (Stree	et and Number or Rura			State, Zip Code)
Nancy L.	Smith	(wife		Greenbe:	Lt Road, #10)1 Gr	eenbelt.	Maryland 2077
20a. Method of Dispo			20b. Place of Dis	position (Name of rematory or other pi	lace)	Dele /13/00	20c. Location - (City or Town, Stale
	Cremetion 3 □R 5 □ Other (Specify)				nal Cemeter		Suitland	,Maryland
21. Signature of Fun	eral Service Licens	00 1 1		22. Neme and Add	ress of Facility			
M	11-6	20.11			. Collins 1			
220 Paris Estati	in the	Mel	The death De set		sity Blvd		lver Spr	ing, MD 20901
shock, or heart	failure. List only or	ne cause on each lin	e.	onter the mode of o	ring, such es cardiac d	r respiratory a	rrast,	Interval Between Onset and Death
Immediele Cause (F	inal				cordinadio my of			7
Immediate Cause (F disease or condition resulting in death)		5.6	were	Grady	corden			monute
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that initiated events resulting in death) La			Due to (or as a cope	Estate State		1		
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Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 15th Year **Physician** MORTON SMITZ 2000 /Medical 4a Facility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) JAN 10, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 187 M 2□ F IDAHO Yrs 346-14-1056 82 Director **Usual Rasidence of Decedent** 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2X No ROCKVILLE MD MONTGOMERY Director notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 23a 5901 MONTROSE ROAD 20852-4723 U. S. A. #N-1302 Funeral 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, etc. 11. Merital Status 1 Green 2 □ No WW II If Yes, Give Year or Datas: 1 ☐ Never Married 2 N Married ò 1 ☐ Yes 2 DtNo Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROFESSOR + EDUCATION 17. Father's Nema (First, Middle, Last) parmit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: If then 27 is marked other any injury or other traumatic event. 18. Mother's Nema (First, Middle, Maiden Sumama) Be FLOYD SMUTZ UNKNOWN 19e. Informant's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) HARUE SMUTZ 5901 MONTROSE RD. ROCKVILLE, MD 20852-4723 20b. Plece of Disposition (Name of cemetery, cremetory or other plece 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremetion 3 ☐ Removel from Stete 5/17/00 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CREMATORY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JOSEPH GAWLER S SONS 5130 WI AVE. NW WASHINGTON, D. C. 20016 Honnbaker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. List only ona cause on each lina. Approximete Inlarval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) SEPSIS /Medical 24 HOURS Examiner Dua to (or as e consequence of): Physician/Medical Examiner PROSTATE CANCER YEARS METASTATIC physician and s the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy 1□ Yes 2☑No 1 ☐ Yes 2 ☐ No this certificate Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 1 PNatural 5 Pending invastigation

certificate be axecuted 68760 Box P.0. Records, Division of Vital or Attending Physician: death. To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu

filed within 72 hours after

3altimore, Maryland 21215-0020

4 ☐ Homicide 29a. Certifier (Check only one)

2 Accident

3 Suicide

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner steted. 29b. Signature end title of certifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

MAY 16,2000

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

ROCKVILLE, MD 20854 MD DR JOSEPH M. HAGGERTY MEDICAL CTR 9707

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

State Registrar

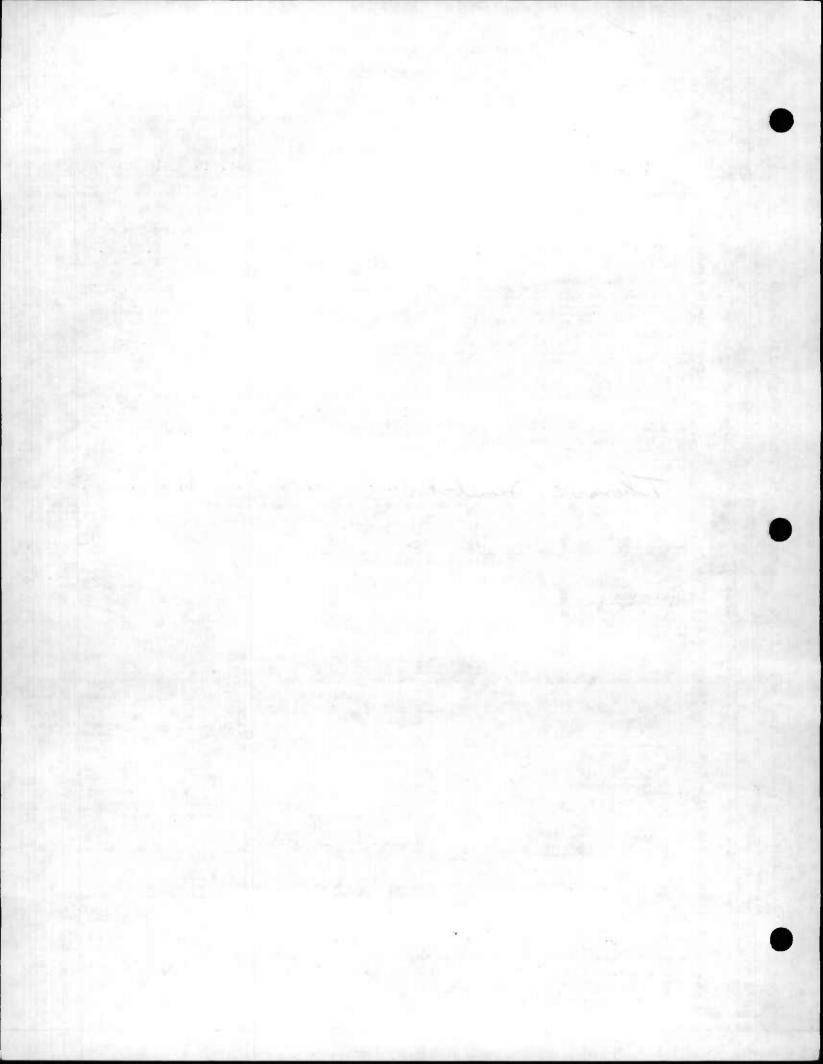
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31. Date filed (Month, Day, Year) 2000 MAY 17

6 Could not be determined

32. Aggistrar's Signeture

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth 3. Time of Death ^{Dey} 2000 Month May 11, **Physician** William J. Sobaski 2211 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Nov. 23, 1935 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 T F Months Deys 349-28-5366 Yrs. 64 Director Illinois Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No 28a-f Directo Maryland Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 must be 238 10701 Out Post Drive 20878 United States Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes: 1954–1955 natural', or flama 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11 Meritel Stetus Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Merried 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Federal Government Economist 18. Mother's Neme (First, Middle, Meiden Sumema) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked othershy lightly or other traumatic event 17. Father's Neme (First, Middle, Last) Be John Sobaski Salome Konieczka 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara G. Sobaski/Wife 10701 Out Post Drive, North Potomac, Maryland 20878 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Slete May 16, 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramovel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, 2000 Bethesda, Maryland Inc. Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funerel Sarviced icenses 0 M00198 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disassa or condition resulting In deeth) /Medical Dreumonitis Examiner Due to (or as a consequence of): Examiner cancer attending physician and for use as the burial-transit certificate be axecuted Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequenca of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of) P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Records, þ 8 should b 24b. Ware autopsy findings eveilable prior to completion of causa of death? Completed 24a. Was an autopsy certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, I Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 10 Inpatient 1 Yes Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

12+1

12 50005 mo GEDNUE

29c. License number D43083 29d. Date signed (Month, Day, Year) 12, 2000

30. Nama end address of person who completed cause of death (Item 23a) (Type, Print)

surge a Sod

9707 medical Center ano \$300 Rochville MD 20880

State Registrar

Medicai

29a. Certifier

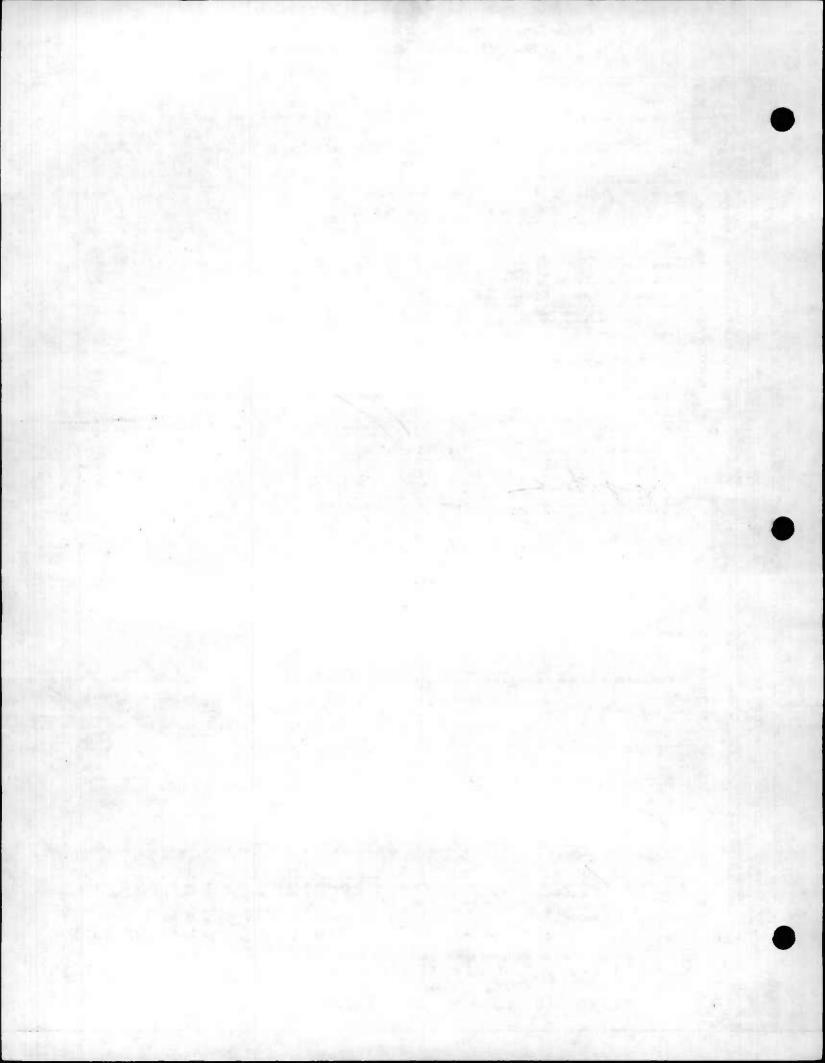
(Check only one)

29b. Signature and title of certifier

31. Dete filed (Month, Day, Year) MAY 15 2000 32. Registrar's Signature

1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2000 9:04 AM Maryann G. Sysko May 16, /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9703 Lawson Place Silver Spring Montgomery If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 20 F Yrs. Director Oct.20, 1934 201-26-8153 Pennsylvania **Usual Residence of Decedent** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural; or itema 23e or 28e-f show any loury or other traumatic event, tra Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Silver Spring Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 9703 Lawson Place 20901-3027 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Merried 21215-0020 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Clerical Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Joseph Gorzkowski Mary E. Lenio 19e. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9703 Lawson Place Silver Spring, Maryland 20901 Fred F. Sysko (husband) 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Ø Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 5/22/00 Wyoming, Pennsylvania Memorial Shrine, Inc. 21. Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part V. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 2 years Breast Cancer Examiner Due to (or as a consequenca of). Examiner The law requires that the death certificate be executed iclan and burial-trans Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Box 68760, Physician/Medical Due to (or as e consequence of): SE 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2₺ No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: Certification: To 1 Yes 2€ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Division or Attanding s after de... al Director: After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homlcide To the Hospital or within 24 hours aft To the Funeral DI completaly filled in Medicai 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 10m D 20062 May 16,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Kannarkat,

MAY 1 8 2000

Tony A. Kanna
31. Date filed (Month, Day, Year)

M.D.

16th Street

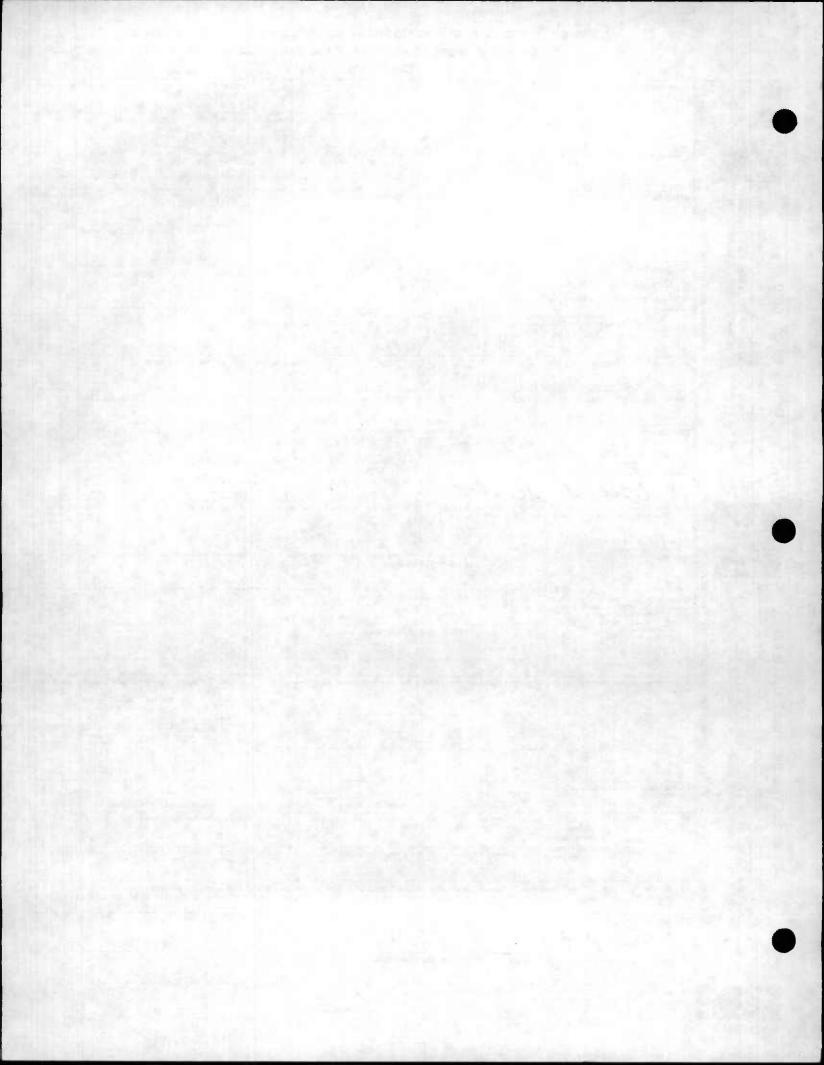
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Silver Spring, Maryland

8201

32. Registrar's Signature

Seneva



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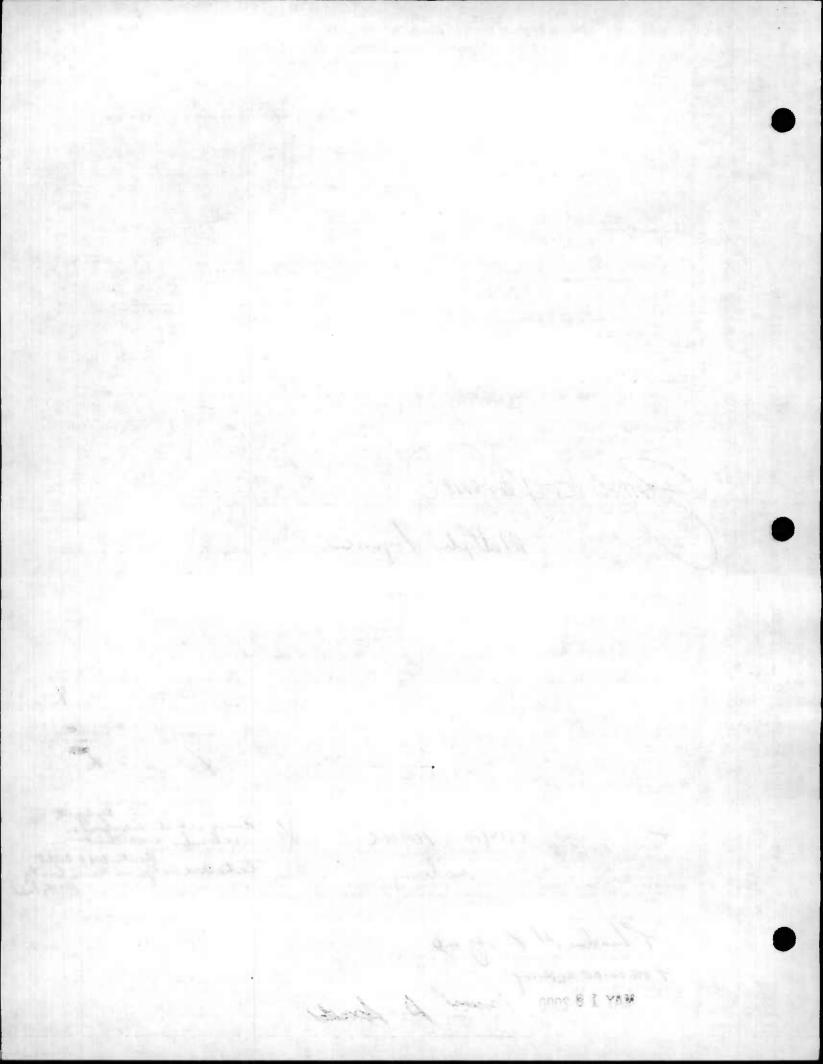
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	State of Maryland / Department of Health and Mental Hygiene	1

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1		1. Decedent's Name (First, Middle, La	2. Date of Deal Month	th Dey	Year	3. Time of Death						
8	Physician /Medical	Dorothy Tweedale					MAY	16,200		5:03P.M.		
	Examiner	4a Facility Name (If not institution, glv EASTON MEMORIAL H				EASTON	or Location of Death	4c. County				
	Funeral Director	311-32-1239		s. <i>last birthda</i> 72 Yrs.	Months Days	fin. 8. Date of Birth fin. (Month, Dey July 25	Year) 9. Birthp Cour 1927 Nort		placa (Stete or Foreign intry) th Carolina			
nore, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours after death with the Maryland in of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Exercises must be notified at To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Queen Anne Chester								10d. Inside City Limits 1 ☐ Yes 2 🔀 No			
th with t	r tems 23s or 28s-fs direc must be notified Funeral Director	10e. Street and Number 405 Merganser (Court		10f. Zip Code 21619			0g. Citizen of 1 USA	What Coul	Hry?		
21215-0020 d within 72 hours after dea	Exeminar or tema	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		(Specify Yes or No- lerto Rican, etc.)	pecify Yes or No- o Rican, etc.) 14. Race Blac Specify				
5-0 72 h	her than "natura nt, me Medical I	15. Decedent's Ed (Specify only highest gra	fucation de completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	eation during most of	working	16b. Kind of B	usiness/In	dustry		
121 (g)	mp han	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	Homemake			Home				
0 P	Hygie Herri	12 17. Father's Name (First, Middle, Last)			Homemake	_	Name (First, Middle,			-		
a a	ed out	Otto B. Williams				10000000	e E. Casey					
Maryland od 2 should be file	Ith and Men 27 is marked traumatic To	19a. Informant's Name/Relationship (Joan Skolnick/Dau				and Number or	Rural Route Number Court Arn	r, City or Town,				
Ballimore,		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control o	Removal from State	cemetery, cr	position (Name of ematory or other pla		May 20 2000 I	20c. Location -	City or To	own, State		
Balt	Department of important: If any injury or other	21 Signature of Foneral Service Union	Lavem	n. /E	22. Name and Addressarranco & 95 Gov. R	Sons,	P.A. Seve	erna Pa	rk Fı	uneral Home MD 21146		
1	nysician Medical xaminer	of a. Part 1. Enter the disease, or comshock, of heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Multiple Due to		1 (Ler Ca)	ng, such as can	ciac or respiratory are	est,	1	Approximate Interval Between Onset and Death		
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_	director, pa	25. Was case referred to medical examiner?				26. Place of	Deeth (Check only or	ne)				
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Di To the Hospital or	within 24 hours To the Funeral completely filled	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, deanation and/or	th occurred et the ti nvestigation, in my o	me, dete and pl opinion, death o	ace, and due to the occurred at the time, o	ause(s) and m lete and place,	enner es : and due !	o the cause(s)		
Toth	To the comp	29b. Signature and title of cartifier Leo done 30. Name and address of person who	4 K + + + + + + + + + + + + + + + + + +	om 23a) (Typ		c.M.E.		29d. Date signe		Day, Year)		
		THEODORE MI				Street	, Baltimor	e, Mar	yland	21201		

State Registrar

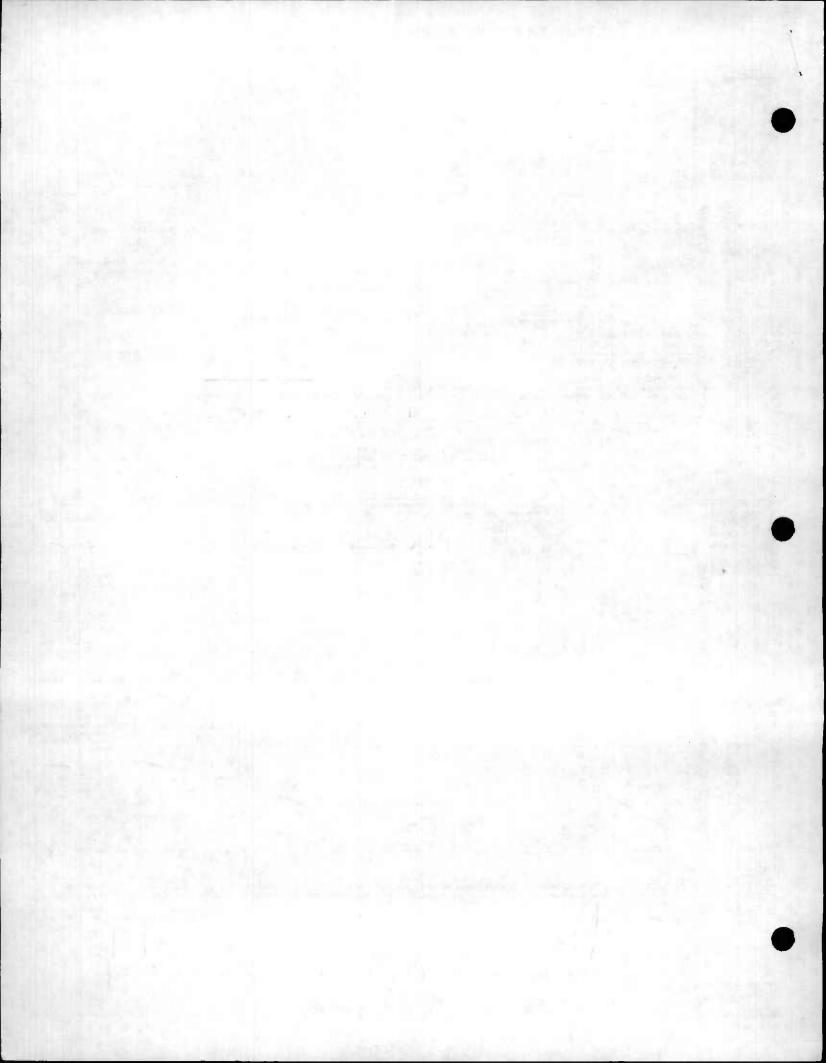
THEOUREME IN 18 31. Date filed (Month, Day, Year)
MAY 18 2000

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 18, per F.D. 5/17/2000, Carroll County, wjl Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 2000 May 16, Zigmund G. Tarutis 2:35 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home Manchester Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days M 2□ F 97 Yrs. 365-12-7453 Director Aug 9,1902 Pennsylvania Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "netural", or items 23s or 28s-f show any fujury or other traumatic evant, the Medical Examinal must be nothing at once. 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits New Bayville 1 Yes 2 No Director Ocean Jersey 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 65 Amherst Road 08721 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3aitimore, Maryland 21215-0020 White If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting C.P.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 George Tarutis Anna Azdolik Anna Dzdolik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Tarutis, sister-in-law 906 Clearview Ave, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/19 Linden, NJ Rosedale Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home Mare Telun 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pu Due to (or es a consequence of): attending physicien for use as the burie P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? been signed by the a should be datached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No Mospital or Attanding Physician:
 24 hours efter death.
 Funeral Director: After this certification by the funeral director,
 in by the funeral director. 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edicai 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examiner stated. (Check only one) ninetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the F within 2 29b. Signature and title 29c. License numbe 29d. Date signed (Month, Day, Year) 3316 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9/114 anow 31. Dale filed (Month, Day, Year) 32. Registrar's Signature State MAY 17 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** May 9, 2000 Margaret Taylor /Medical 12:56 am 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year Birthplaca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1 M 200 Yrs 80 Director March14, 1919 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 280-11 Howard Elkridge 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 6045 Old Washington Road 21075 U.S.A. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after 8 Department of Heelih and Mentel Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic avant, the Medical Exercipes once. 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes XIX No Specify: Specify: White 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Home Maker Home
18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 8 (Unobtainable) (Unobtainable) 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 6045 Old Washington Road Elkridge, Maryland 21075 ce of Disposition (Nerme of Date 20c. Location - City or Town, State Mary Oakley Grandaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) XX Burial 2 Cremation 3 Removal from State 5-13-00 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Vermillion Chapell 21. Signature of Faneral Service Licent 22. Name and Address of Facility 4M00843 Gary L. Kaufman F.H. Meadowridge Memorial Park Mens 7250 Washington Boulvard Elkridge, Maryland21075 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): schrobic the burial-trensit The lew requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. neilensive Cardiovas Physician/Medical Due to (or as a consequence of): been signed by the s should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hemodele page 2 s 10 No 1 ☐ Yes 2 ☐ No MRSA Wound Physician: 25. Was case reterred to medical examiner?

1 Yes 2 No 8 26. Place of Death (Check only one), Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Compatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Natural 5 Pending or Attending To the Hospital ... within 24 hours after death.
To the Funeral Director: A' death. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, tactory, offica building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar TUNG

31. Date filed (Month, Dey,

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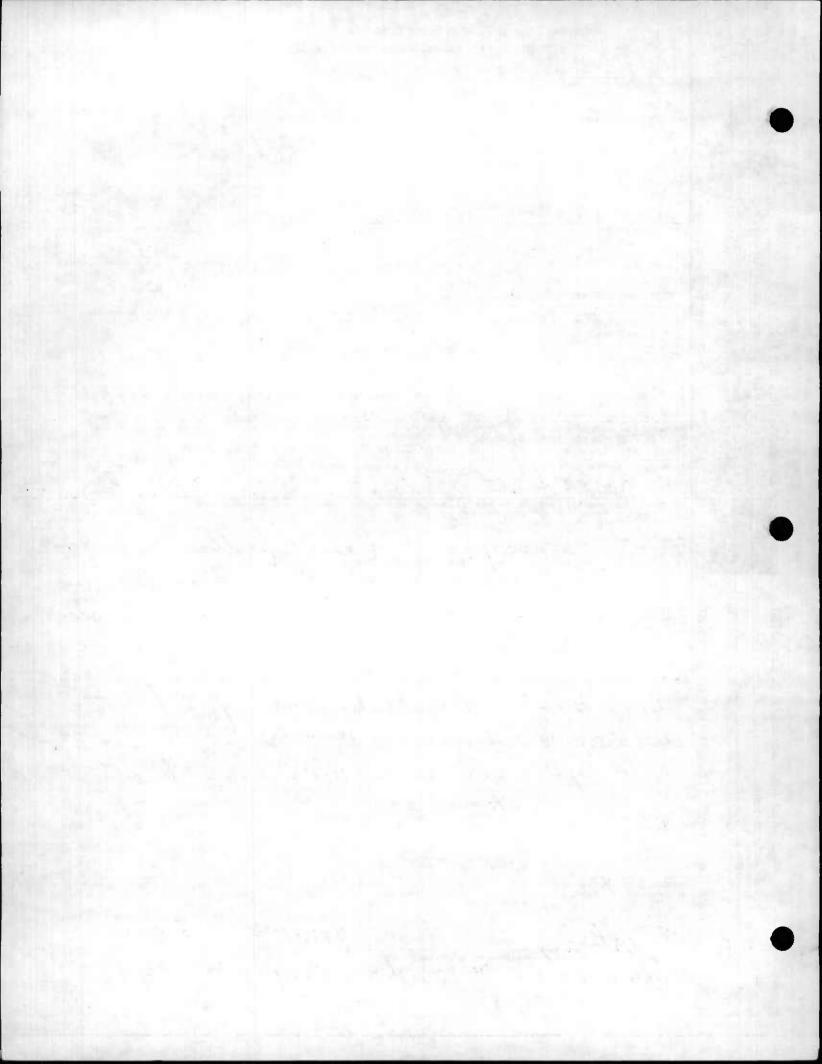
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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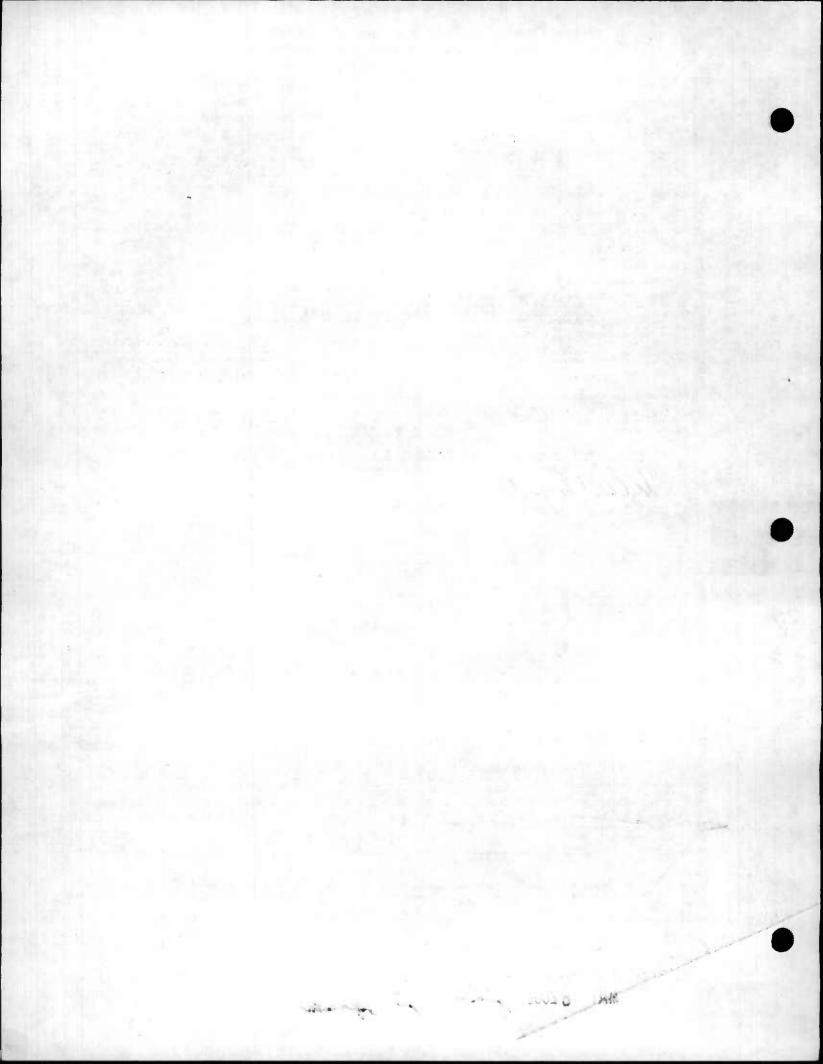
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** MAY 2000 Richard Stephen Tobin /Medical 4b. City, Town, or Location of Death 4a Fscility Name (If not institution, give street and number) 4c. County of Death Examiner Harford Fallston Fallston General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country) March 7, 1945 New Jersey 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days NOM 20 F Yes Director 157-32-1645
Usual Residence of Decedent 55 r 28a-f ahow 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 → No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? al', or hams 23a or 21047 TISA 2708 Beckon Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. to yes 2 No
If Yes, Give
Year or Dates.Vietnam 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Ith and Mental Hygiena. 27 is marked other than "r r traumatic avant, my Med Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Government Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any Injury or other traumatic avant, page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Maraza John P. Tobin Stephen 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Vernon La., Chatham, New Jersey 07928 Barbara Tobin/ Sister Baltimore, 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Cemetery 5-9-00 Jersey City, New Jersey 22. Name and Address of Fecility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List part one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical 5epsis Examiner Due to (or es a consequence of): Physician/Medical Examiner Congestive heart 148ar Sequentially list conditions, if any, leading to immediale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Cardiomyopatho Due to (or es a consequence of) arterydisease 4ears covonava Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of desth? 1 Yes 25 No 3 Probably 4 Unknown Diabetes Mellitus Completed by 24b. Were autopsy findings available prior to completion of cause of death? Renal insufficiency 24e. Wes an sutopsy performed? Hyperlipidemia 1 □ Yes 2 No certificate Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Aftar 1-64 Natural 5 Pending investigation 1 | Yes 2 | No To the Hospital or Attenditional within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Localion (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the csuse(s) and manner as ststed.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29e. Cartifier completaly (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2241 Michael Norman Drossner MD. 104 Plumtice Rd Suite 110, Bel Air, Maryland 21013 State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2 Date of Death 3 Time of Death 2000^{Year} Day **Physician** 11:51 A.M 3 May Beverly June Travers /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford Hours Min. June 2, 1939 If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Months Days Maryland 1 M 2874F 213-36-8578 Yrs 60 Director Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3153 Aldino Road 21028 mast b U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat.
Department of Health and Mental Hygiene.
Important: if Nem 27 is marked other than any Injury or other traumed. 12. Was Decedent Evar in U,S Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11 Marital Status Black, Whita, alc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 1 Yes 2 TNo Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use refired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be LeRoy O'Connor Esther Sears 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Kenneth C. Travers (Husband) 3153 Aldino Road, Churchville, Maryland 21028 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Baker Cemetery 5/6/00 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signalura of Funaral Sarvice Licenses Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** CAUDIOM YOURATHY

Dua to (or as a consequence of):

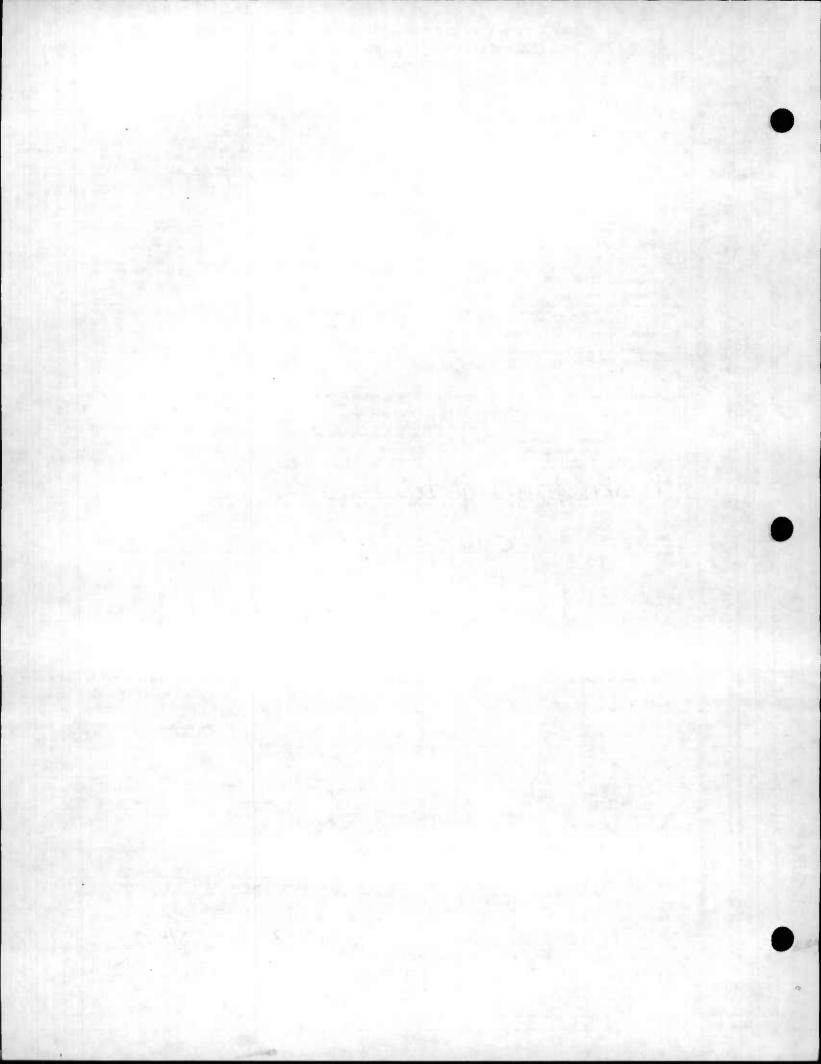
PULMOUTIVY HYOUTETEUSION

Dua to (or as a consequence of): tmmediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury CACLDIONASCULAL 0/5/5/5/5 P.O. Box 68760. that initiated evants rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 2 No 3 Probably 4 Unknown CIBSTILLICTIVE LUNG DISEASE Records, ģ 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate. of Vital 25. Was casa rafarred to medical axaminar? 28. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No death. 2 Accident after death 6 Could not be datamined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by ti 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) 219W. BELHU ECK TU 32 Registrar's Signatura State 31. Data filed (Many, Year) 2000

Registrar

Bererly



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7428 Certificate of Death 1. Decedant's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 0.5 Month Day **EDWARD** ANTHONY TAPPE 14 2000 8:00AM 4a Fecility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death ROSA NURSING HOME VILLA MITCHELLVILLE PRINCE GEORGE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 2/15/1910 9. Birthplece (Stata or Foreign 7. Age (In yrs. last birthday) 5. Sociel Security Number Months Days Hours PENNSYLVANIA 10XM 2□ F 90 Yrs. 167-01-8942 Usuel Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Ves 2 No MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 CRESTMOOR CIRCLE 20910 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status TYPS 2 No If Yas, Give Year or Detas: 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Quilege (1-4or 5+) PILOT AIRLINES 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM C. TAPPE ANNA ARKIN 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 20901 19a. Informant's Name/Relationship (Type, Print) ALICE TAPPE (WIFE) 200 CRESTMOOR CIRCLE, SILVER SPRING, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GEORGETOWN MED SCH.5/14/00 WASHINGTON, D.C. 4 Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility AUSTIN ROYSTER FUNERAL HOME 821 14TH ST. N.W. WASH, DC. nerel Service Licen HOME 20011 a, or complications that caused tha daath. Demail enter tha mode of dying, such es cardiac or respiratory arrest, List only one cause on each lina. Approximata interval Batween Onset and Death 23a. Part1. Enter the dig DOZI Immediate Cause (Final Vermia disease or condition rasulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in daath) Last Due to (or as a consequence ot): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Pert I. 23b. Did tobacco usa contributa to the causs of death? 1 Yss 2 No 3 □ Probably □ Unknown 24b. Were autopsy tindings evailable prior to completion of cause 24a. Was en eutopsy No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was casa reterred to medical examiner? 26. Place of Death (Chack only one) Other: Surring Home 5 Residence 6 Other (Specify) 1 Yas No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima ot 28d. Describe how injury occurred Natural 5 Panding Investigation 1 Yes 2 Accident

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

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perm. Pages 1 and 2 should be filed within 72 hours efter death with the Merylen Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at

ettending physician end for use es the buriel-transit signed by the

P.O. Box 68760.

Division of Vital Records,

After this certificate has funeral director, page 2

The law requires that the deeth certificate be executed Hospital or Attending Physician: 724 hours after death.
Funeral Director: After this certifica stelly filled in by the funeral director, p To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Physician/Medical Examiner þ Completed Be P Certification:

Medical

State

3 Suicide

29a. Cartifier

29b. Signature

4 Homicide

(Check only one)

RICHARD FELDMAN, 31. Date tiled (Month, Day, Year)

6 Could not be determined

30. Name and address of person with completed causa of death (Item 23a) (Type, Print) M.D.

32. Registrar's Signature

28e. Place of Injury - At home, farm, straet, tactory, office building, etc. (Specify)

9500 ANNAPOLIS ROAD #A4, LANHAM, MARYLAND

29c. License number

iii: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

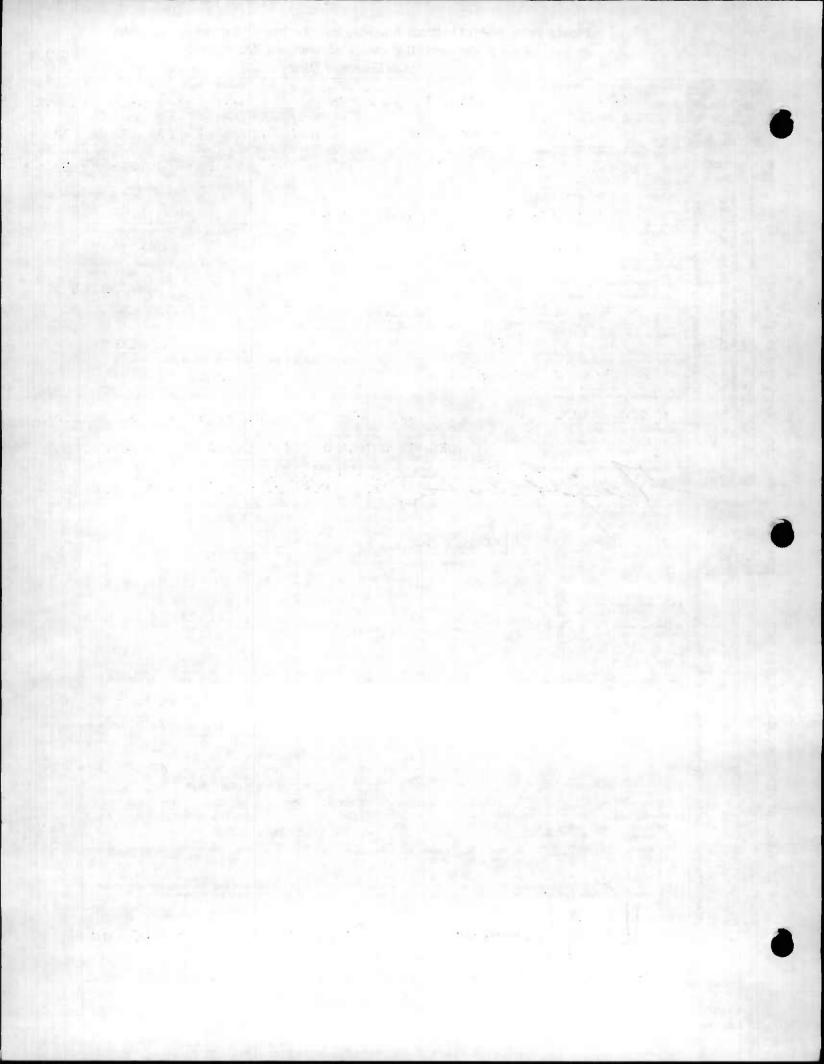
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28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

-00

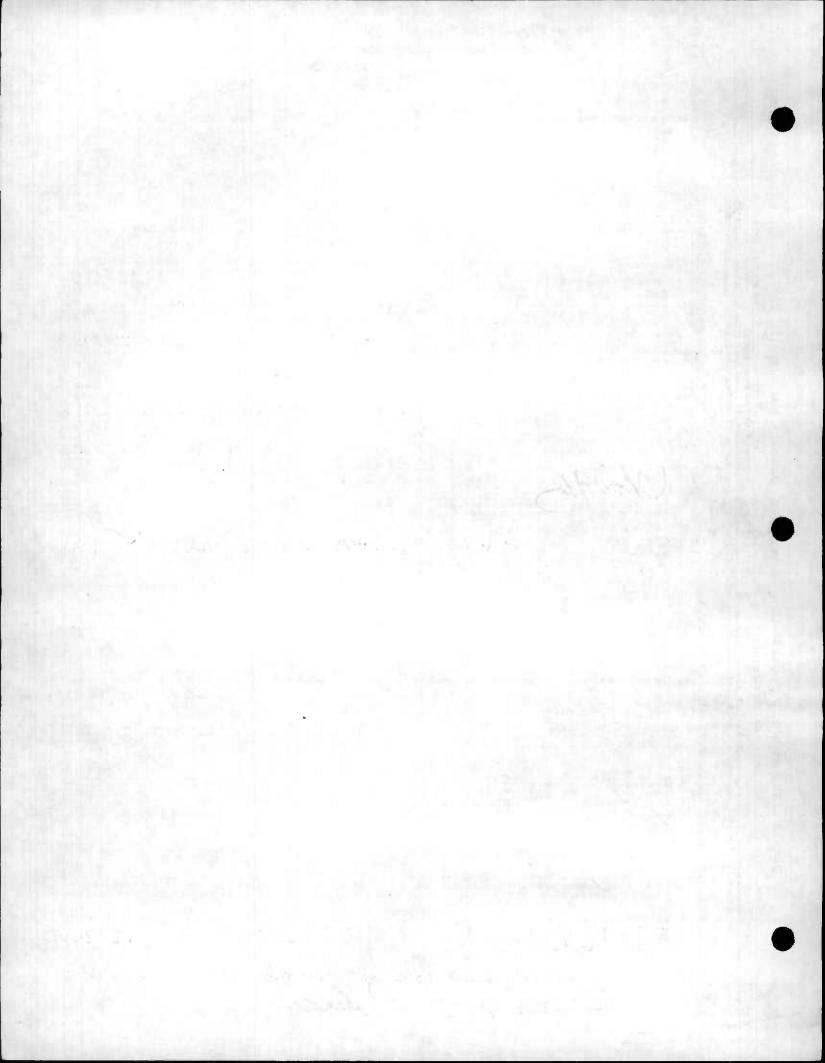
Beneva MAY 19 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death th 12, 2000 Month MAY **Physician** JOHN WAYNE UTZ 3:25 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REISTERSTOWN FUTURE CARE-CHERRYWOOD HEALTH CARE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month. Day. Year) 8 / 2 2 / 1 9 4 2 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign Country) MARYLAND **Funeral** 11 M 2□ F 215-40-1486 Director **Usual Residence of Decedent** 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at ¥ Yas 2 No Director CARROLL MD. WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 48 PENNSYLVANIA AVE. 21157 USA. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE À 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PAINTER CONSTRUCTION 9 other permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If fem 27 is marked othe any injury or other traumadic avent, bace. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 8 RAYMOND MONROE UTZ FLORENCE BARNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAYMOND D. UTZ -BROTHER 44 HOUCKSVILLE RD., HAMPSTEAD, MD. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Steta 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from State 5/12/00 METRO CREMATORY BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Batween Onset and Death **Physician** Adenocascinoma of head and Neck Immediata Cause (Finat disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician and d for use as the burial-transit The law requires that the death certificate be axecuted Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 19 1es 2□No 3 Probably 4 Unknown à cate has been sign, page 2 should b 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 2 DNo 1 Tes certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.
To the Funeral Director: After this certifica completely filled in by the funeral director, i 8 25. Was case referred to medical 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signalian and title of certifier 2000 12 ceuse of death (Item 23a) (Type, Print) Greentree Rd Pikesville MD 21208 0 1838 Hunter Copelan CM 31. Data filed (Month, Day, Year) 32. Registrar's Signature State MAY 12 2000

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death VON HENDRICKS **Physician** HENRIETTE 4b. City, Town, or Location of Death /Medical 2000 5:15 am 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner BALTIMORE NONE FUTURE CARE -HOMEWOOD Munder 1 Year | Munder 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 212 F Yrs. Director 214-72-2457 Usual Residence of Decedent 64 FEB. 6 1936 GERMANY 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow rai', or items 23a or 28a-f ahov Examiner must be notified at 1 XYes 2 No Director MARYLAND ANNE ARUNDEL GAMBRILLS 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2264 MISTHAVEN LANE 21054 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. e filed within 72 hours after al Hygiene. other than "natural", or ite 1 Never Married 2 Merried 1 Yes 2 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th HOUSEWIFE NONE permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Itam 27 is marked oths any Injury or other traumatic avant, pince. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) MAX LENNERT SUCKER MARGARETA MENGES 19a. Informent's Neme/Reletionship (Type, Print) (HUSBAND) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BURNELL F. VON HENDRICKS 2264 MISTHAVEN LA. GAMBRILLS, MD. 21054 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Buriat 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) MARYLAND VETERAN 5/22/00 CROWNSVILLE, MD. 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Leese MO048ZWM. REESE & SONS MORTUARY, P.A. 1821 WEST ST. ANNAPOLIS, MD. 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Probable Cardiac arry/hma Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by t should be detact 1 | Yes 2 | No 3 | Probably 6 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4H Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 28e. Dete of injury (Month, Day Year) 28c. Injury at Work? 27. Menger of Deeth 28d. Describe how injury occurred 28b. Time of 1 Neturel 2 Accident 5 Pending 1 Yes 2 No investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

The law requires that the deeth certificate be executed P.O. Box 68760 Records. Division of Vital Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certificaleta filled in by the funeral director.

Baltimore, Maryland 21215-0020

29e. Certifie (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

29c. License number
1) 30641

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sahapathi Svite 30 8 821 N. Eutaw Sr Hallime MD2120)

State Registrar 31. Dete filed (Month, Dey, Year)

MAY 1 9 2000

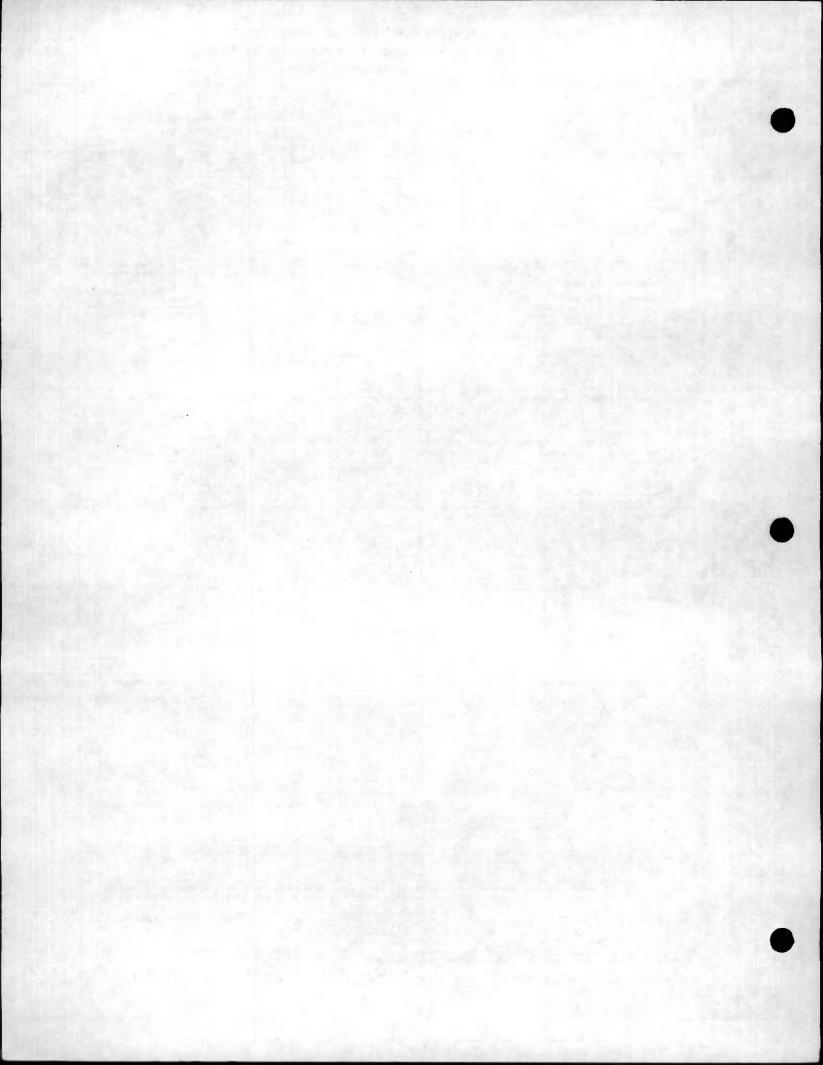
32. Registrar's Signeture

To the Hosp within 24 hos To the Fune completaly fi

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 17431

aryland 21215-0020 should be filed within 72 hours after death with the Maryland and Mental Hyglene. And Mental Hyglene. And Mental Hyglene. Fraument of the maryland of t	Mariner Heal Social Security Number 331-20-5051 Usual Residence of Decedent 10a. State 10b. County 1aryland Balt 10c. Street and Number 57 Carling Ci 11. Marital Status 1 Never Married 3 Widowed 15. Decedent's (Specify only highest of Security Only highest of Security Only 15. Teather's Name (First, Middle, La Anthony Ceh 19e. Intorment's Neme/Reletionship	tek pive street and num. th Of Or Sex 1 M 2 M F imore 12. Was Deced Armed For 1 Yes, Give Year or Dat Education prade completed) College (1-4	Verlea 7. Age (In yrs. 74) 10c. City Lar Jest Per in U.	yrs. Yrs. Yrs. Yrs. Yrs. Yrs. Yrs. Yrs. Yrs. Yrs. Yrs.	Months ocation ne 101. Zig Was Dece If Yes, spe 1 Yes	Deys Code 212 dent of Heiry Cube 223 No	Balti If Under 24 Hours	2. Date of Month Ay , or Location of De .more Hrs. 8. Dete of Month, Jan, of	14, Pay 20 Seath 4c. Cou N/A Birth Pay, Year 926 10g. Citizen Unite No- 14. F	9. Birth Cook Mar	plece (State or Fon infr) Y I and 10d. Inside City Lin 1 □ Yes 2 % intry? ates	
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altimore, mit. Pages 1 en parlment of Health portant: if Item 2: y Injury or other 25.	20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 5/16/00 Beltsvi											
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20	29b. Signature and telerof suddies	un	m	2	29	C. Licens	2834	K	29d. Date si	15/0	Dey, Year)	
3	30. Name and address of person wh	o completed cause	of deeth (Item	23a) (Type	Print)	to	N I	RN, E	Bacto	m	> 2121	



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2 Date of Death 3. Time of Death Year **Physician** Marion E. Walker 2.20pm 2000 /Medical 4b. City, Town, or Lucation of Death 4c. County of Death 49 Facility Neme (If not Institution, give street end number) Examiner 8. Date of Birth (Month, Day, Nov. 2, 9. Birthplaca (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 214-09-7063 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 1201 Edmonston Drive United States 238 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Never Merried 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumetic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Bertha Creek George Mann 19a. tnforment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jacqueline A. Howes/Daughter 1201 Edmonston Drive, Rockville, Maryland 20851 Saltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 16, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 2000 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Ligensee M00198 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of): Examiner HNEMIC Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or e Due to (or as a consequence of): 23b. Dfd tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, PV 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy performed? 1 Yes 20 No 1 ☐ Yas 2 ☐ No conficate 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2√No 2 # 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Division 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident after desti Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 4 Homicide 6 24 hours a Funeral C Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29e. Certifier Medical (Check only within 2 To the i å 29c. License number 29d. Date signed (Month, Day, Year) 5-12-00

State Registrar THEMAS JUHNSON DRIVE, FREDERICK, WID

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

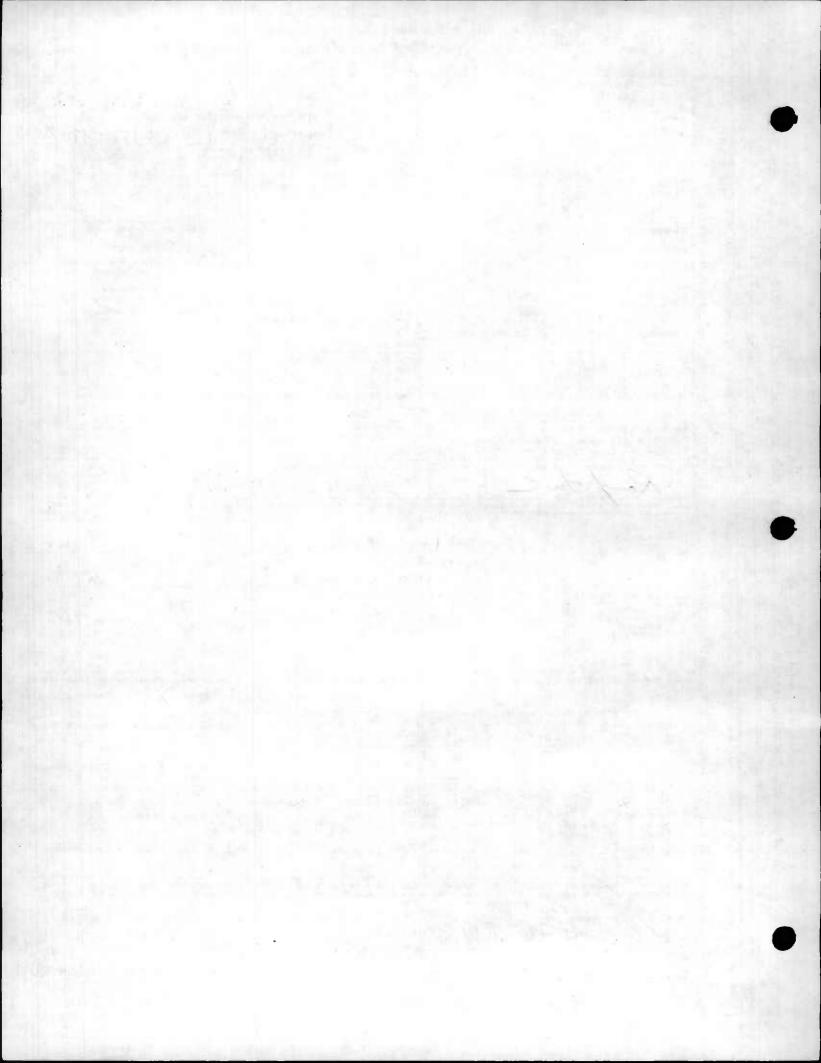
32. Registrar's Signature

WILLIAM H. JOHNSON, 172

2000

31. Date filed (Month, Dey, Year)

MAY 15



DHMH 16 Rev 6/95

Registrar

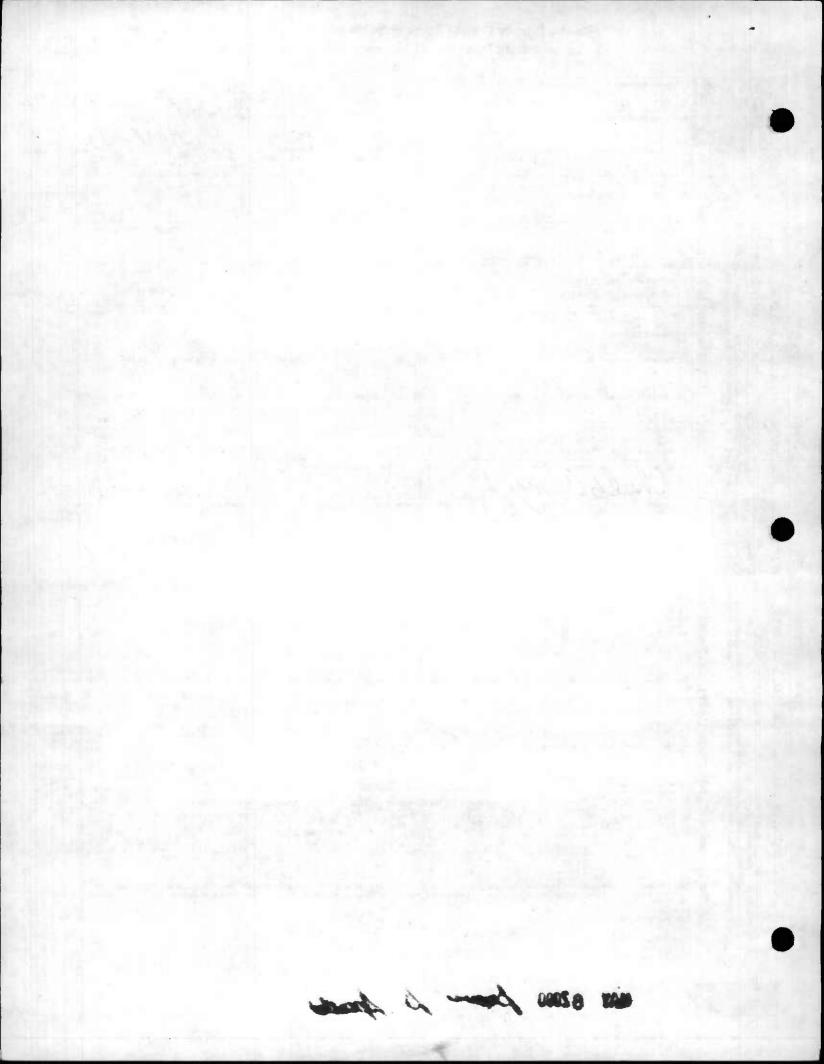
2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Year Month Physician 9:47 A 2000 Virgie Ethel Whitley MAY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MARFURI Lorien Nursing & Rehabilatation Center Belcamp If Under 1 Year Months Days If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birtholace (State or Foreign Country) **Funeral** 1□ M 2⊠F 81 Yrs. Director 212-28-1286 Usuat Residence of Decedent Sept. 16,1918 Nebraska 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens . Important: if item 27 is marked other than "natural", or frams 23a or 28a-f ahov with fully or other treumatic avent, the Madical Examiner must be notified at Disc. 1 Yes 2 No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 Robinhood Road 21078 USA Funeral 11. Marital Stalus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dales: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Packing Shoe Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Andrew Jackson Vipperman Eva Marie Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Dotson/ Daughter 1478 Doctor Jack Road, Conowingo, MD 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 □ Donation 5 □ Other (Specify) Harford Memorial Gardens 5-10-00 Aldino, Maryland 21. Signatury of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part1. Enler the disease, or complications that caused the death. Do not enler the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only use cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximete Intervet Between Onsel and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) Acute exacerbation of Congestive heart /Medical Examiner Due to (or as a consequence of): Examiner physicien and s the burlei-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760, Physician/Medical Due to (or es a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? algned by t Chronei obstructue Put. 1 ☐ Yes 2 ☐ No 3 Probably 4⊠Unknown Records, à 24b. Were eutopsy findings available prior to page 2 should Completed Hypenensian 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No certificata of Vital or Attending Physicien: director, 25. Was case referred to medical examiner? B 26. Place of Deeth (Check only one) Other: 4 Unring Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA the state funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Division After Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation To the Hospital or Attandi within 24 hours attandeath To the Funeral Director: A completely filled in by the f 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stele) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier MIRZA A-BAIG MD FACE License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Ave Union Grace, MD Havre

Registrar

State



State of Maryland / Department of Health and			14.35
Certificate of Death	Reg. No.		
Last)	2. Date of Death Month Day	Year	3. Tima of Death

Physician /Medical Examiner

1. Decedent's Name (First, Middle.

Funeral Director

the Maryland "natural", or ! I Hyglene.

item 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic event, the Moulcal Examinar must be notified at death filed within 72 hours after Pages 1 and 2 should be nent of Health end Mental Department of Health end Important: If Item 27 is me 8

altimore, Maryland 21215-0020

Physician /Medical **Examiner**

The law requires that the deeth certificate be executed attending physician end for use as the buriel-trensit Box 68760 signed by the aid be deteched for Division of Vital Records, P.O. peed hes page this certificate After this certification, funeral director, or Attending Physician: death. within 24 hours efter death To the Funeral Director: completely filled in by the Hospital

May 12, 2000 2:00 p.m Velton Rusell Wagner 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 4660 Bicknell Road Marbury Charles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Months XXM 2DF 215-44-6140 68 January 23, 1932 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Directo Maryland Charles Marbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4660 Bicknell Road United States 20658 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritel Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 8 Farmer Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Romey Wagner Julian Downey 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Wagner/Brother Same as #10 200 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 17 Pate Method of Disposition

1D Burial 2 Cremation 3 Removal from State

Wesley Chapel Cemetery May Rock Hall, Maryland e of Funeral 21. Signat 22. Name and Address of Facility P.A. 20640 Williams Funeral Home, M00668 4270 Hawthorne Road, Indian Head, Maryland

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart-failure. List only one cause on each line.

Approximate Interval Between Onset and Death M00668 Immediate Cause (Final a D O Cener 5 math disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☑ No 3 Probably 4 Unknown by 24b. Were eutopsy findings -available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) To 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 1 Natural Injun 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Medical 112 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number 0/1/76 Mayle

ause of death (Item 23a) (Type, Print)

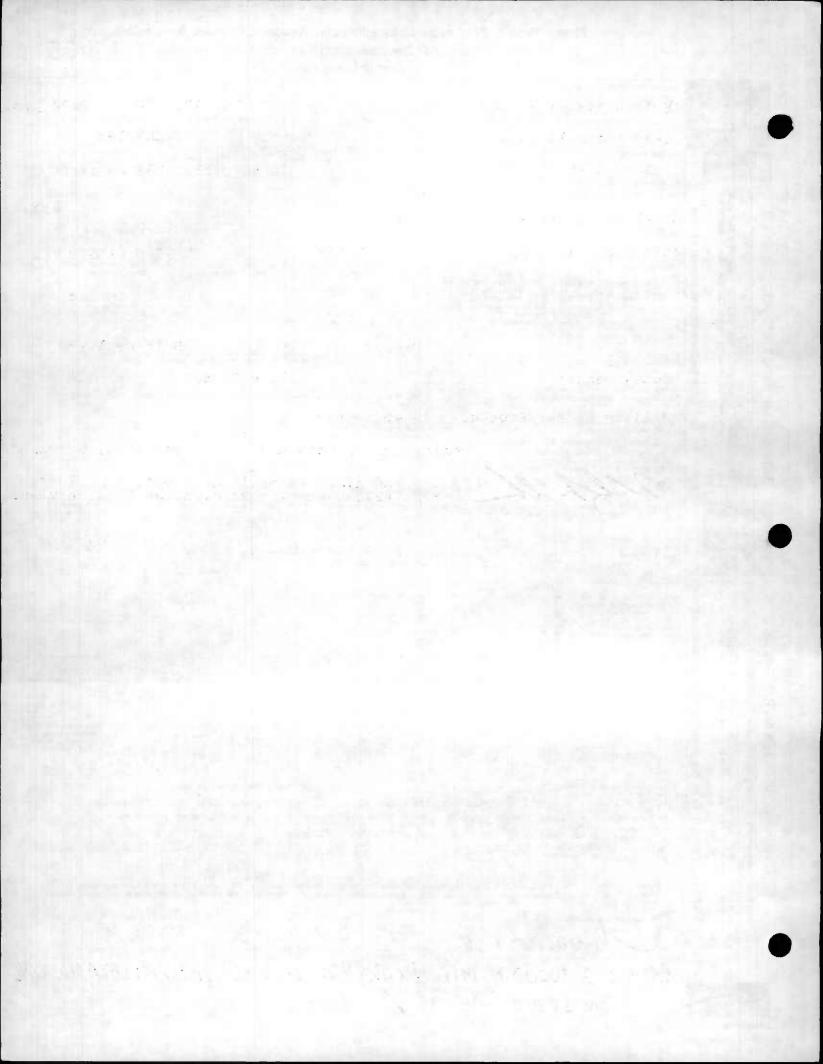
32. Aegistrar's Signature

WOODDY, M.D

P.O. BOX 430 100 WASH. AVE LAPLATA MD. 20646

State Registrar 31. Date filed (Month, Day, Year)

MAY 17 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 7436 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2000 12:35 p.m. 16 Orania C., Wariti May 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1712 Lansdowne Way Silver Spring Montgomery if Undar 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthpiece (State or Foreign Country) Months Days Hours 1□ M 2√2 F 67 577-80-5156 Yrs. Sept 16,1932 Thailand Usuat Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1712 20910 Landdowne Way IISA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Asian 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Central Supply Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Moch Wariti Kongcom Atawut 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nongnooch Pragani/ Sister Rt. 5 Box 353 H, Martinsburg, WV 25401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2000 17, Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Francis J. Collins Funeral Home nc., 500 University Blvd West, Silver Spring 21. Signature of Funaral Service Licenses Inc., 500 MD. 20901 triver 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death cardiovascular disease Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 200 No 3 Probably 4 Unknown 1 Yes 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 2 X No 20 No 1 ☐ Yes 1 Yas

Physician /Medical Examiner

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Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice

To the Hospital or within 24 hours eft To the Funeral Dil completely filled in

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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permit. Peges t and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mentel Hygiene. Important: If Item 27 is merked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exament must be notified and page.

altimore, Maryland 21215-0020

the Marylend

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

26. Place of Death (Check only one)

25. Was case referred to medical aminer? 1 Yes 2 No 27. Manner of Deeth 5 Pending investigation 1 Netural 2 Accident 3 Suicide 6 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Homa 5 Nesidence 6 Other (Specify) 28c. Injury at Work? 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner es steled.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. Licensa number

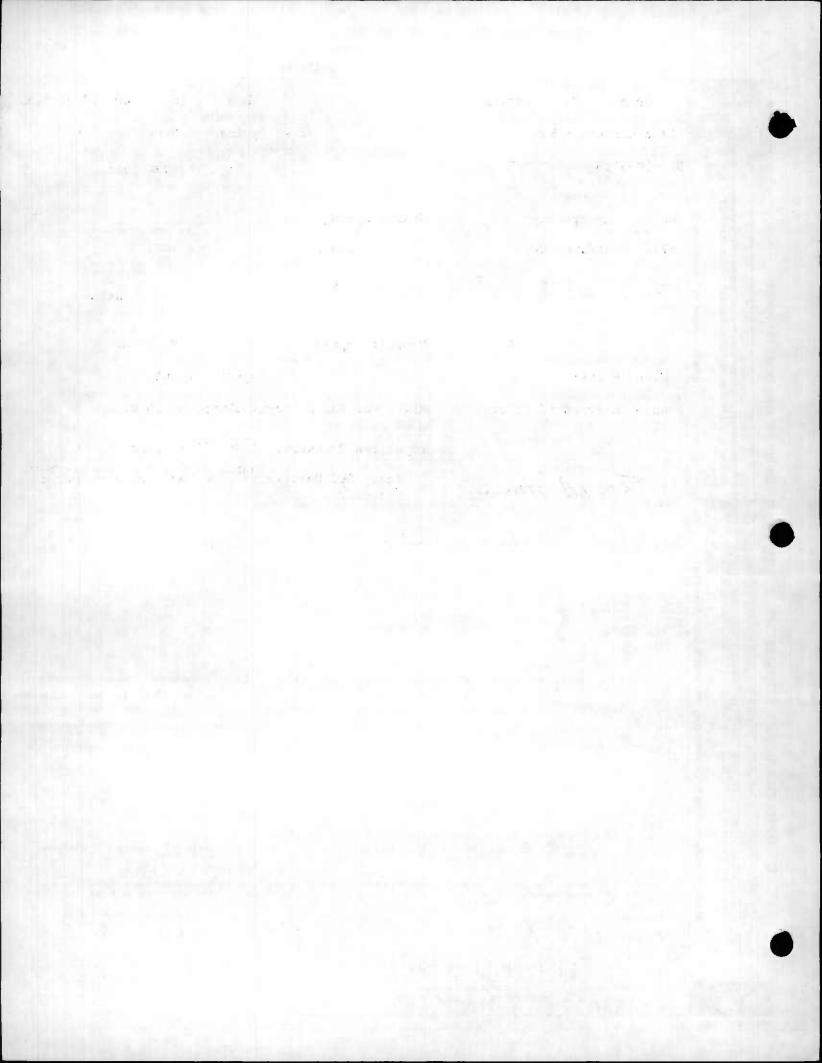
29d. Date signed (Month, Day, Year) May 10,200

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31. Date filed (Month, Day, Year)

32. Registrar's Signatura

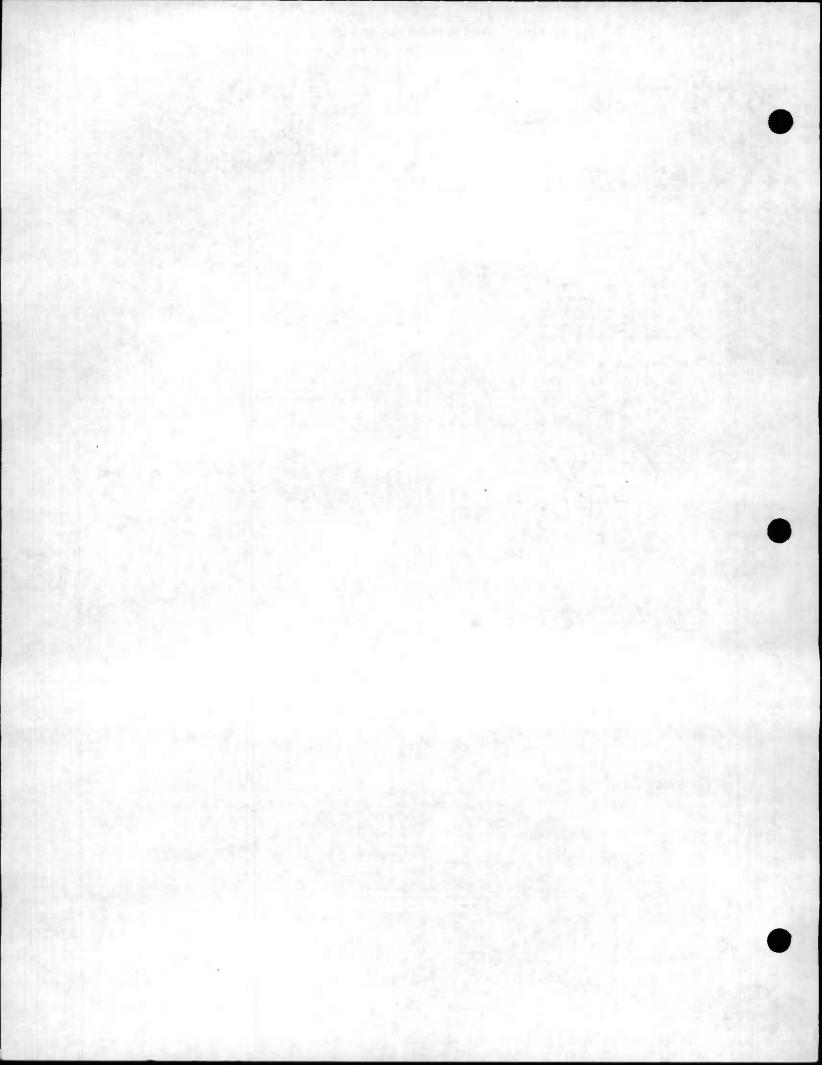
State Registrar



State of Maryland / Department of Health and M	Mental Hygiene
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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death MAY 16, **Physician** 2000 1:49 AM WEEKS PHYLLIS ANN /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 8. Date of Birth (Month, Day, Year)
May 3, 1930 If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10 M 20 F 577-36-8763 70 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manjand Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or item 23s or 28s-4 show any Injury or other traumatic event, the Medical Examinal must be notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Funeral Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20855 16612 Killdeer Drive United States 13. Wes Decedent of Hispantc Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: by Specity: 3 Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Receptionist Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Powell Essie Alice Louderback Chapman John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) Lee Powell Weeks, 16612 Killdeer Drive, Rockville, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other piece) May 16, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rep wal from State 4 Donation 5 ☐ Other (Specify Metropolitan Crematory 2000 Alexandria, Virginia 21. Sign ture of Fas eral Service Li 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) intravascular coagulation Mours Examiner Due to (or as a consequenca of) Physician/Medical Examiner perforation ntestinal YLUON hysician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760. ntestinal obstruction Due to (or as a consequenca of) USB BS ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Be Completed completion of cause of death? After this certificate has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No edical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funerel C To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

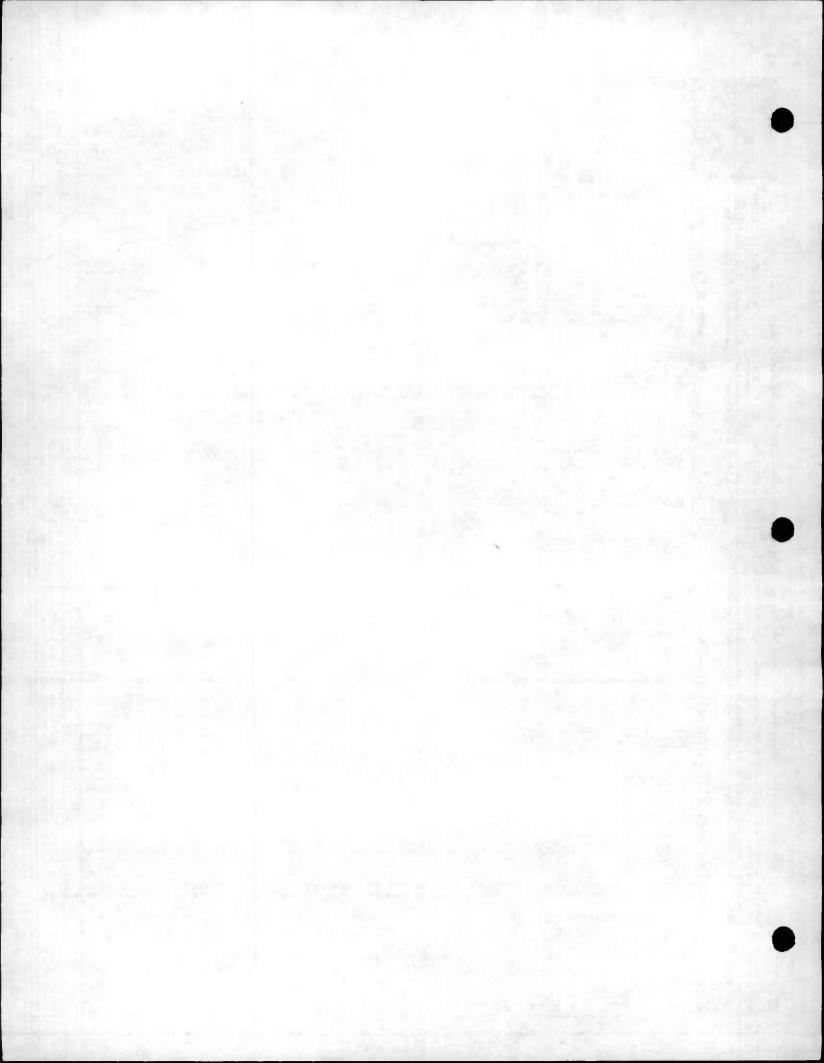
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 16 0 313 G 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20879 481 N. Frederick Avenue, Gaithersburg, Maryland S. Abulfarag, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 18 2000 Registrar parks



State of Maryland / Department of Health and Mental Hygiene 0 17438

			Cei	rtificate of	Death		Reg. No.			
	1. Decedent's Neme (First, Middle, Las	st)	11			2. Dete of De Month	eath	Year	3. Time of Death	
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Funeral	5. Social Security Number 6. S		. last birthday)	If Under 1 Yea		8. Dete of Bi	rth New Year)	9. Birthr	plece (State or Foreign	
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9	Usuel Rasidence of Decedent									
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A 84		Rd.		20815		United	State	S		
death rms 23	/801 Jones Bridge 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in I	pecify Yes or No Rican, etc.))- 14. Re	ca - Americ					
Or after		Armed Forcas? 1 ☐ Yas 2 ☒ No	Hican, etc.)	Bla	ck, Whita,	atc.				
0020 hours after hours, or h	3 Widowed 4 □ Divorced	If Yes, Giva Year or Detes:		1□Yes 250 No	Specify:		Specif	Whi	.te	
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ylan Mental Mental erked o	Emanuel George Zio	es			Violetta	Anna R	levs Str	ott		
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumetic event, the Medical Examitations of the marked that the marked trains of the marked trains	19e. Informent's Name/Raletionship (7	Type, Print)	19b. Mailir	na Addrass (Stree	at and Number or Ru	ral Route Numb	er. City or Town	Stete. Zic	Code)	
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Phys or this eral di	27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of				how injury occur		,,	
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DIVISION C tall or Attanding P is after death. al Director: After t led in by the funer	3 Suicide 6 Could not be		nome farm str			28f. Location	Street and Num	ber or Run	el Route Number,	
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DIVISION To the Hospital or Attant within 24 hours after deal To the Funeral Director: completely filled in by the		relates. To the head of much						The section of the		
ne Kospi n 24 hou he Funer pletely fil	(Check only 2 Medical Exam	ysician: To the best of my knowner: On the basis of examin-	owiedge, death etion and/or inv	restigation, in my	opinion, daath occur	red at the time,	date end pleca,	annar as a and due to	tated. o the ceuse(s)	
To the To the comple		and manner stated.		200 Lines	an aumbar		20d Data size	at 18 family	Day Kand	
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	30. Nama and address of person who c	completed causa of death (tte			IA de	20	calle v	0-	20257	
	A RATVANSI	11 MD 121 ver	yesso	on al L	n #400	1 KOUK	A June	NI I	20 83 2	
State	31. Dete filed (Month, Day, Year)	32. Røgistrar's Sign		- /						
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CHEVERLY MD 20785

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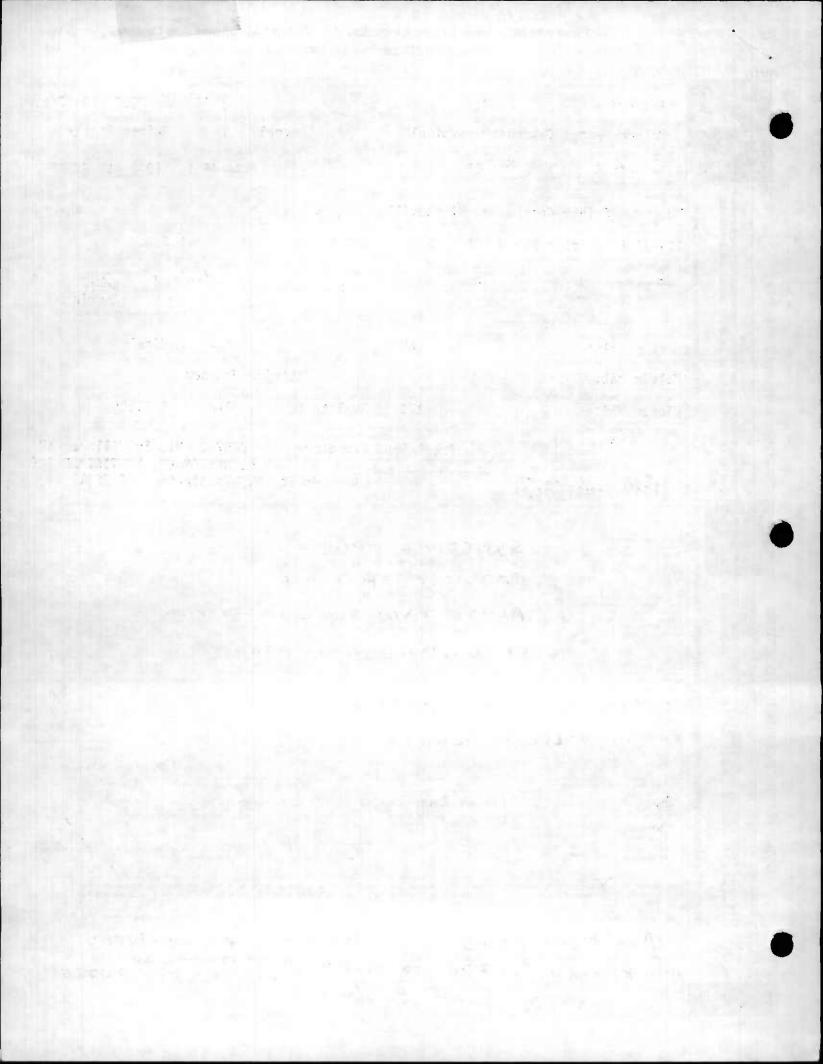
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CM. WACAHAM. X. JIMA

2000

31. Data filad (Month, Day, Year)

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Bertie Maxine N. Willard May 18, 2000 6:05 am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing and Wellness Center Rockville Montgomery 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Nov 7, 190 5. Social Security Number 6. Sax **Funeral** Days 1□M 20 F 90 Yrs. 1909 Missouri Director 495-68-6695 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No notifie Directo Maryland | Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ed other than "natural", or items 23s or event, the Medical Examiner must be r 4313 Landgreen Street 20853 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian 11. Marital Stefus Black, Whita, etc. 1 Nevar Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yas 20 No Specify: Yas Give ğ 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home pamil. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If then 27 is marked other any injury or other treumstic event, and any injury or other treumstic event, and as the second other treumstic 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be Joseph M. Nelson Alberta Maxfield 2 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Corena Nadine Farris 4313 Landgreen Street, Rockville, MD 20853 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ABurial 2 Cramation 3 Removal from Stata 5/25/00 Van Buren, Missouri 4 ☐ Donation 5 ☐ Othar (Specify) Van Buren Cemetery 21. Signature of Funaral Sarvice Licenser 22. Nama and Addrass of Facility FrancisoJ. Collins Funeral Home, Inc. nue 500 University Blvd., W, Silver Spring, MD 20901 23e. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Pneumonia Examiner Dua to (or as a consequence of): nding physician and certificate be executed Sequantially list conditions, if eny, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initieted evants rasulting in death) Last Dua to (or as a consequance of): Box 68760. Physician/Medical Due to (or es a consequence of): USB as for u P.O. I signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia Records. þ The law requires 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 hes 1 ☐ Yes 2 X No 1 ☐ Yes 2 No certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificalety filled in by the funeral director. 25. Was casa rafarred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yes 2N No 1 Inpatiant 2 ER/Outpatient 3 DOA 2 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be datarmined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida The control of the cause (s) and manner as stated.

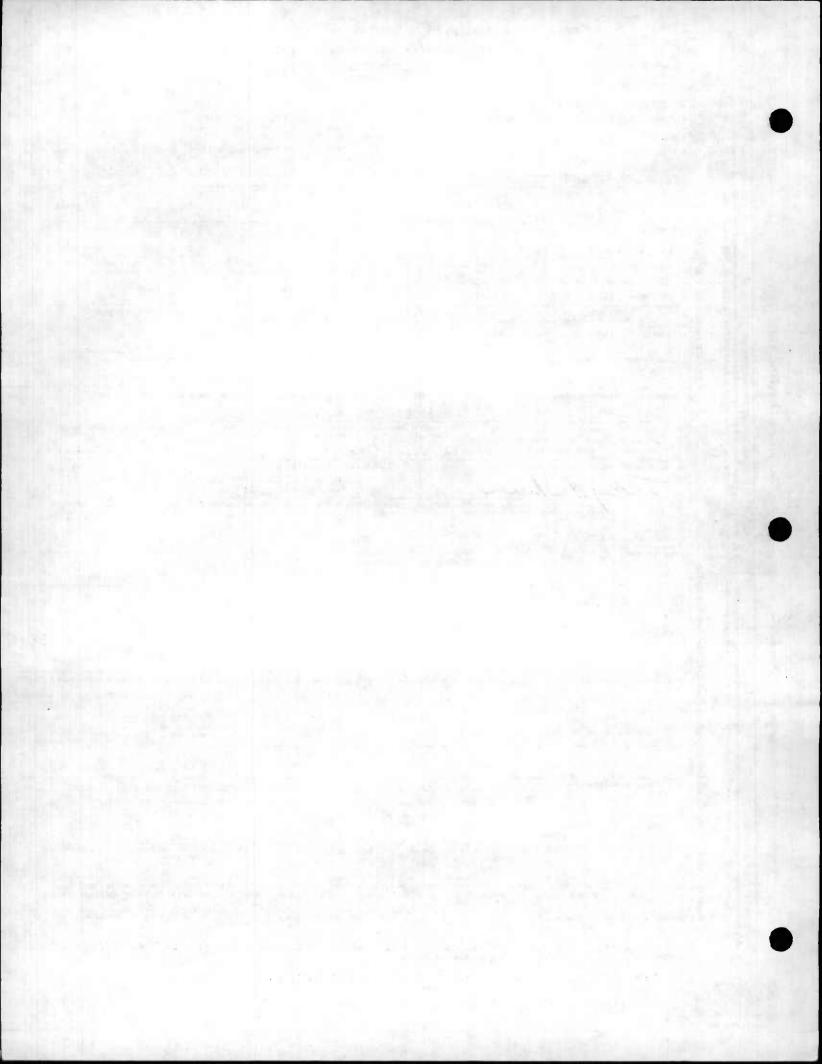
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause (s) and manner stated. 29a. Certifier Medical npletely (Check only one) To the Viniting 29b. Signatura and titla of certifian 29c. License number 29d. Data signed (Month, Day, Year) 3 D 35791 May 18, 2000 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 9801 20902 Merlyn Vemury, MD Georgia Ave., Silver Spring, MD 31. Data filed (Month, Day, Year) 32. Registrer's Signeture State

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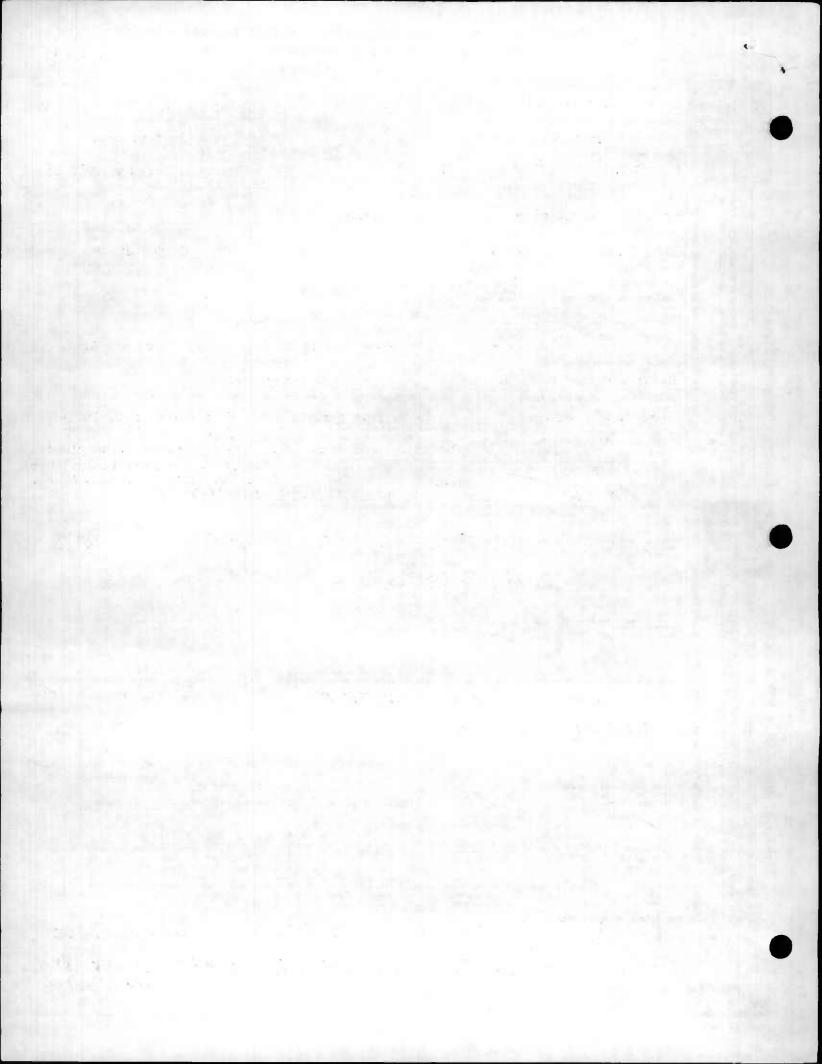
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month Year **Physician** Hessel Davis Witten May 10, 2000 2:43 PM /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Montgomery General Hospital 01ney Montgomery If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yaar) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□ F Hours 87 Yrs Director 155-05-0841 January 1, 1913 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heelth and Mental Hyglene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f ahov any Injury or other traumatic event, the Medical Exempet must be notified at once. 1 ☐ Yes 2X No Directo Maryland Montgomery Silver Spring 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 3701 International Drive 20906 United States Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 12 Yes 2 □ Na # Yes, Give Year or Dates: Kore. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Nidowed 4 Divorced White Korea Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Businessman Hardware Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herbert Witten Fanny Davis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger M. Witten/Son 5101 Yuma Street, N.W., Washington, D.C. 20016 May 12, 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, Stata 1 ☐ Buriai 2 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2000 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Fuperal Servica Licansee Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, M01126 Bethesda, Maryland 20814-3501 23a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onsat and Death **Physician** MULTIPLE ORGAN PAMURE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of):

LEROSCLEROTIC CARDIOVASCULAR PISEASE Examiner physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of) d for use es t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the a should be detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy After this certificete has funeral director, page 2 2 1 NO 1 T Ves 2 TING 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residenca 8 Othar (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Impatient 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of injury - At home, farm, straat, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and placa, and due to the ceuse(s) and manner stated. 29b. Signature and life of certifie 29d. Date signed (Month, Day, Year) 29c. Licensa number 9+1 mpleted cause of death from 230), Type Bright MATIONAL DR #211, SWER SPRINGE WWD, 3801 IMERNATIONAL DR #211, SWER SPRINGE UM 1/2 31. Data filad (Month, Day, Yaar) 32. Registrar's Signatura State

Registrar

MAY 17



Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

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Funeral

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Hygiene.

permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: if them 27 is marked other th
any Injury or other traumatic event, IIIs
DDGS.

Maryland 21215-0020

Saltimore,

physician end s the burial-transit ettending ph signed by the e certificete hes b

that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Attending Physician:

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After

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To the Hosp within 24 hor To the Fune completely fi

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Examiner Physician/Medical ρ Completed Be 1º funerel Certification: efter death.

Director: Aft
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26. Piece of Deeth (Check only one)

25. Wes cese referred to medical examiner? 1 Nes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of injury (Month, Dey Year) 27. Manner of Deeth 5 Pending Investigation 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Certifying Physicfan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.

**To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner steled.

**To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner steled.

28d. Describe how injury occurred

29b. Signat

- NO. (OMA) 29c. License number 015236

29d. Dete signed (Month, Dey, Year) MAY 9, 2000

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

CARL I MARGOLIK, M.O. (OME) 11125 POCKWILLE PIKE, POCKVILLE, MO 20852

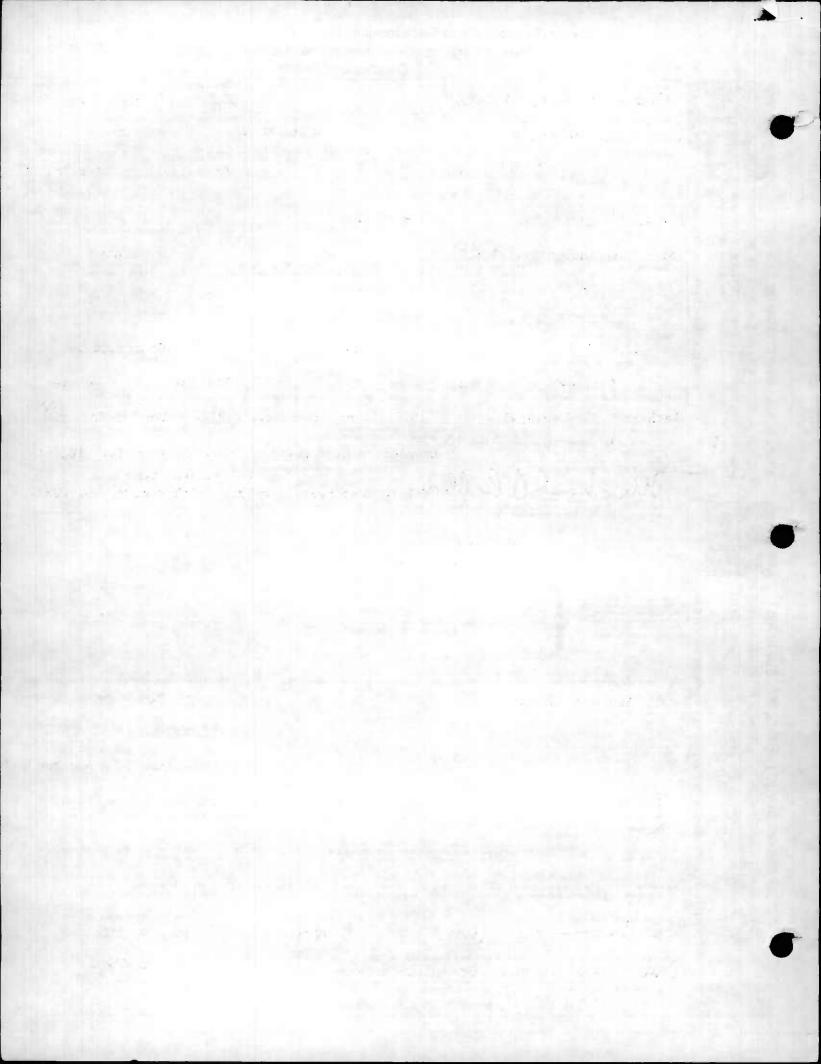
State Registrar

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31. Date filed (Month, Dey, Year) MAY 16 2000 32. Registrer's Signature Deneva



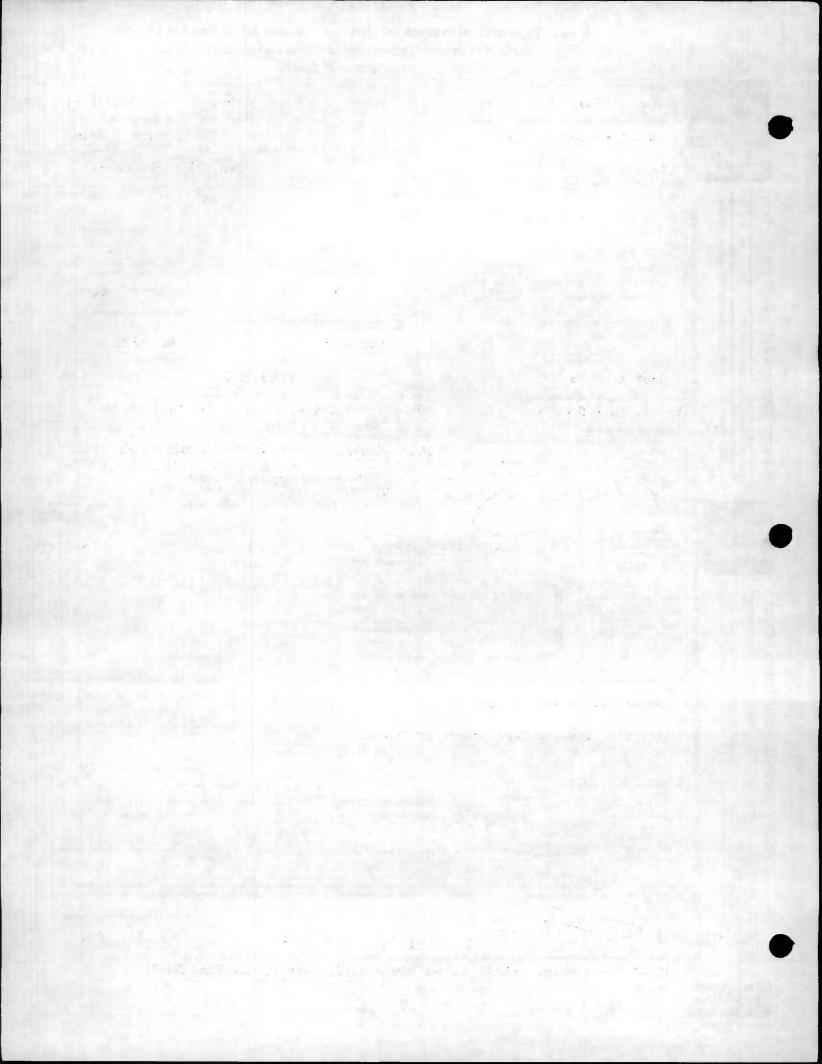
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Day 17 **Physician** 2000 Tae Chu May 1:01 AM /Medical 4a Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Laurel Regional Hospital Laurel Prince Georges 8. Dafe of Birth (Month, Day, Year)
Dec. 29, 1926 Korea If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 15€M 2□ F Yrs 73 Director 216-68-2241 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show Hygiene. other than "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notified at 1 Tyes 2 No Maryland Directo Prince Georges Lanham 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 9407 Wyatt Drive 20706 USA Funeral Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, Whife, etc. 12. Was Decadent Ever in U,S. Armed Forces? 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Introportant: If item 27 is marked other than "natural", or itel injury or other treumatic event, the Medical Example DDG. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Naver Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ Asian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Duck Moon Yu Gan Nan Cho 19a. fnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Bok I. Yu / Spouse 9407 Wyatt Drive, Lanham, Maryland 20706 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State Norbeck Memorial Park 05/19/00 Olney, Maryland 4 Donation 5 Othar (Specify 2) Signature of Funeral Service 22. Nama and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue 20904 Silver Spring, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition rasulting in daath) /Medical 4 hours Aspiration Pneumonia Examiner Due to (or as a consequenca of): Examiner The law requires that the deeth certificate be executed physician end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or es a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): 60 use ō Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Cerebrovascular Accident s been signed to should be dete ģ 24b. Were autopsy findings available prior fo completion of cause of death? 24a. Was an autopsy Completed Arteriosclerotic Cardiovascular Disease performed? After this certificate hes funeral director, page 2 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica stely filled in by the funeral director, i Be 25. Was case rafarred to medical 26. Placa of Daath (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Natural 5 Panding investigation 1 Yes 2 No 2 Accident n 24 hours efter dea ne Funeral Director nolately filled in by th 6 Could not be datermined 3 Sulcide 28e. Placa of Injury - Af home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical completely (Check only one) To the within 2 29b. Signature and little of certifier a 29d. Date signed (Month, Day, Year) 29c. License number D24721 May 17, 2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 14333 Laurel Bowie Road, Laurel, Maryland 20708 Syed Sadiq, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

MAY 19

2000



State of Maryland / Department of Health and Mental Hygiene

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			Ce	ertifica	te of	Death		R	eg. No.		
	1. Decedent's Name (First, Middle, Last)						2. Date of Deal	h Dav	Year	3. Time of Death
Physician /Medical	Dorothy	YOU	se.				E	MAY		2000	7:08AN
Examiner	4a Facility Name (If not institution, give					4b. City, To		ation of Death	4c. County		1
	Howard cour	ity Hosk	oital			Colu	mb	ia	How	ard	county
uneral irector	5. Social Security Number 6. Se 212-05-2525	7. Age (n yrs. last birthday	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Pay 2-25	Year) 18	9. Birthpla Countr Mary	ce (State or Foreign Land
	Usual Residenca of Decedent										
II I	10a. Stete 10b. County	1	Dc. City, Town or t	Location						10	d. Inside City Limits
recto	MD Carroll		Sykesvi	ille							1 ☐ Yes 2 No
Dire	10e. Street and Number				Code			1	0g. Citizen of	What Counti	yγ
Puneral I	12490 Indian Hill	Drive		2	1784				USA		
by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 2 2 3 No If Yes, Give Yeer or Dates:	or in U,S. 13	Was Dece If Yes, spe 1 Yes	cify Cub	lispanic Ori an, Mexican Specify:	gin? (Spec i, Puerto P	cify Yes or No- lican, etc.)		ca - America ck, White, e Whi	lc.
Completed	15. Decedent's Edu (Specify only highest grad	location	16a. Dec	edent's Usu	al Occup	eation	t of workin	va .	16b. Kind of B	usiness/Indu	ustry
omple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DONOT	se retire	during most	LOI WOIKH	9			
ő	12	Ø	Home	emaker					Own I	lome	
Be	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle, I	Maiden Sumar	ne)	
To Be C	August Falck					He1	en Di	udrow	March.		
	19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Ma	iting Addres	s (Street	and Numbe	er or Rural	Route Number	, City or Town	State, Zip (Code)
	John Walter Youse	, Jr./Husba	and 124	490 Ir	diar	Hill	Dri	ve, Syk	esville	, MD	21784
	20a. Method of Disposition		20b. Place of Disp	position (Na	me of other pla	ce)		Date	20c. Location	- City or Tow	m, State
5	1 Burial 2 □ Cremation 3 □ F Donation 5 □ Other (Specify)		Loudon I	Park (emet	erv	5	/19 B	altimor	e. Ma	rvland
	21. Signature of Furtieral Service Licens	Dp				2		zke Fun			
8	1 amal	hall.	The second secon					ue, Cat			
	23a. Part1. Enter the disease of comp shock, or heart failure. List only o	daying of	00/2/								Approximate
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	Sept Sept	ted, consider to for estatic to for as a conse	Jane equence of Lux	Per 19	nous fore Car	Su ated ncer	nall I Colo	n	24	
clan/		o								101	
ysk	Part II. Other eignificant conditions con	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	_		cause giv	ven in Part I		23b. Dld to	bacco uee co		the causs of death?
by Physician	Atrial Fib	rillation	, ren	al :	fai	lux	2	1 U Y	es 2 No	3 Prob	ably 4 Unknow
should leted				ı				24a. Was a perfor		ava	re autopsy findings ilable prior to apletion of cause eath?
Сотр								10 Y	es 2 No	10	Yes 2 No
To Be C	25. Was case referred to medical					26 Place	of Death	(Check only or	-	1	
ToB	examiner? 1 ☐ Yes 2 💢 No	Hospital:	2 ☐ ER/Outpati	ent 3 D	OA Oth	Jer. –		ne 5 Resid		ner (Specify)
	27. Manner of Death	28a. Date of Injury	28b. Time	of	28c. inju			8d. Describe h			
힅	1 Natural 5 Pending Investigation	(Month, Day Y	ear) Injury	М		Yes 2	No				
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, s Specify)	street, facto	ry, offica		2	8f. Location (S City or Tow	treet and Num n, State)	ber or Rural	Route Number,
Medical Certifical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of n ner: On the basis of ex and manner state	amination and/or i	ath occurred	et the ti	me, date en opinion, dea	d piece, e ith occurre	nd due to the o	ause(s) and m late and place,	anner as sta and due to	ited. the cause(s)
E E	29b. Signature and title of certifier					se number		2	9d. Date signs	ed (Month, D	Pay, Year)
completely filled in by the Medical Certifical	> Unach th	2000	H.D.				768	(Marco 10		
0	30. Name end address of person who con 716, Maiden	mycen				ا م	100	1	100 16	the 20	000
V	30. Name end address of person who co	ompleted cause of deal	h (Item 23a) (Type	e, Print)	MCV	ille	MI	212	28.		
	116, Malgen	-noice L	1110,0	_010	1 (7) X	1110	1.1) - 217			
State	31. Date filed (Month, Day, Year)	32. Registrer's	Signature	9	1						

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State of Maryland / Department of Health and Mental Hygiene 00 17445

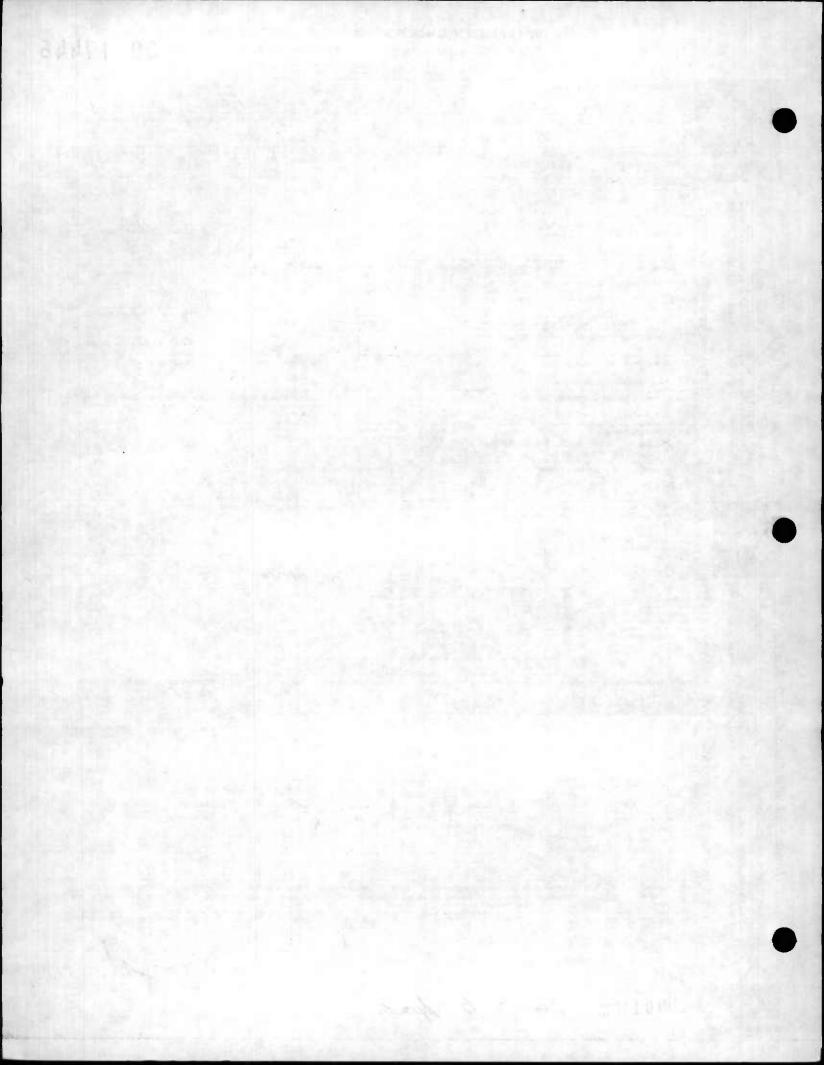
					3111100	10 01	Death		1	Reg. No.			
an	1. Decedent's Name (First, Middle,		N. Tri						2. Date of Dea	ath Day	Year		ima of Death
յ 		Frank	lin L	ee Au	stin,	Sr.			May	26	200		30 P.N
	4a Facifity Name (If not institution, g	give street and nur	nber)				•		ocation of Death	4c. Co	ounty of De	ath	
	Deaton Specia	lty Hosp	ital					timo:			N/.	A	
		. Sex 1 M 2 □ F	7. Age (In yrs		y) If Unde Months	or 1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Dete of Birt (Month, Day	h y, Year)	9. B	irthplace (S Country)	State or Fore
	218-40-2440	IGM ZUF	58	Yrs.					June 2	5,194	1 We	st V	irgini
	Usual Residence of Decedent 10e. State 10b. County		100 0	City, Town or I	Location							10d Inc	ide City Lim
ı		I/A	100.0	nly, rown or i	LOCABOT	Ba	1 time	re C	itv				Yes 2 1
	-	1/ A			Baltimore City								2163 201
ı	10e. Street and Number				10f. Z	ip Code				10g. Citize			
Į	414 S. Robinson	Street					2122		United States				
I	11. Marital Status	12. Was Dece Armed Fo	edent Ever in loces?	U,S. 13	B. Was Deci	edent of tecify Cub	Hispanic Or an, Mexice	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	. 14.	. Race - An Black, Wh		ian,
	1 Never Merried 28 Married	1 ☐ Yes If Yes, Giv	2 No		1 ☐ Yes						pecify:		
	3 Widowed 4 Divorced	Year or D	etes:								N	White	
	15. Decedent's (Specify only highest (Education grade completed)		16a. Dec	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						of Busines	ss/Industry	
ı	Elementary/Secondary (0-12)	College (1	-4or 5+)				od)				916		
	8 Years			F	Roofer		1		4481		ne Imp	rover	ment
	17. Fether's Name (First, Middle, La								e (First, Middle,	Maiden Su	ımame)		
	Benjamin Austin	1		4.0			Lau	ra P	itzer				
	19e. Informant's Neme/Relationship Mrs. Kathryn H.		(Wife)		-				al Route Number t Balt				
-	20a. Method of Disposition			Place of Dis				T	Date		tion - City		
	1⊠ Buriaf 2 ☐ Cremation 3		State	cemetery, cr	rematory or	other pla	- 1-	7 /20					
ļ	4 ☐ Donation 5 ☐ Other (Spe		Oa	k Lawr				1/20	100	Balt	imore	e, Mai	cyland
	21. Signature of Funeral Service Lic	ensee	0		22, Name a					D 3	11 4		
eny Injury	Done.	E'Ka	-						ome of dalk, M			21222	
	23a. Part1. Enter the octage, or on shock, or heart failure. List on	mplications that o	eused the dea	ath. Do not e	enter the mo	de of dy	ing, such as	cerdiac	or respiratory ar	rest,			oximate val Between
	SHOCK, OF HEART LANGE. CLAY CO.											Onse	t and Death
ical iner	Immediate Cause (Final						ubTIC:	atlo	ns and				
ı	Immediate Cause (Final disease or condition resulting in death)		cic Sp	inal F	ractu	re	MDTIC	atlo	ns and	1			
	disease or condition		cic Sp		ractu	re	MDTIC	atlo	ns and	6			
	disease or condition resulting in death)		cic Sp. Due to	inal F:	ractu	re):	mplic	atlo	ns and	lay			
	disease or condition resulting in death)		cic Sp. Due to	inal F	ractu	re):	mplica	atlo	ns and	lax.	56		
	disease or condition resulting in death)		Due to	inal F: (or as a cons	ractu: equence of	re):	mplic	atlo	ns and	lay	1		
	disease or condition		Due to	inal F:	ractu: equence of	re):	mplic	atlo	ns and	Lay.	A cy		
	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		Due to	inal F: (or as a cons	ractu: equence of	re):	mplica	ation	ns and	lox.	A Section of the sect	W.	
2001	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a Thorac	Due to	inal F. (or as a cons	ractu equence of equence of	re):			4	lox.	A. S.	w.C.	
200	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a Thorac	Due to	inal F. (or as a cons	ractu equence of equence of	re):			23b. Dld	- WO I TO		La.	eauss of dea
200	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a Thorac	Due to	inal F. (or as a cons	ractu equence of equence of	re):			23b. Dld	tobecco us		La.	eauss of dea *XXX Unkn
,	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a Thorac	Due to	inal F. (or as a cons	ractu equence of equence of	re):			23b. Did 1	Yss 2	No 3	Probably	XX Unkn
,	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a Thorac	Due to	inal F. (or as a cons	ractu equence of equence of	re):			23b. Dld 1 1 24e. Was perfo	Yss 2	No 3	b. Were au available completi	topsy finding prior to on of cause
	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a Thorac	Due to	inal F. (or as a cons	ractu equence of equence of	re):			23b. Did 1	Yss 2	No 3	b. Were au available	topsy finding prior to on of cause
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	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Thorac	Due to	inal F. (or as a cons	ractu equence of equence of	ceuse g	ven in Part	1.	23b. Did to 1	an autopsymed? /al Yes 2 // 2	No 3 24	b. Were au available completi	topsy finding prior to on of cause
	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical	a. Thorac	Due to Due to Due to	inal F. (or as a cons	ractu: requence of equence of	ceuse g	ven in Part	I.	23b. Did to 1	an autopsymed? /al Yes 2 pone) dence 6 [No 3 D	b. Were au available completi of death	topsy finding prior to on of cause
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State of Maryland / Department of Health and Mental Hygiene 00

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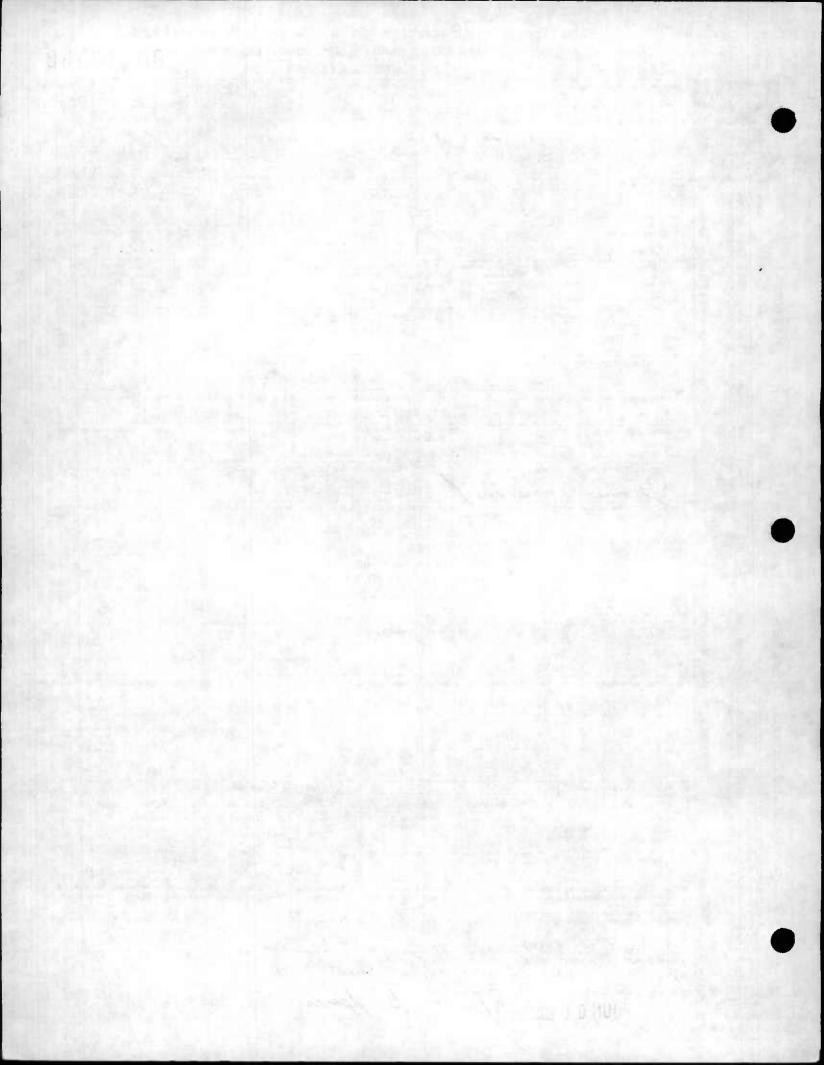
					Cert	incate of	Dealli		Reg. No.		
ician dical	Decedent's Name	A 1 .	CE	1	Adan	15		2. Date of De Month	Day	Year	3. Time of Deet 12:01 A
	la Facility Name (If	not institution, giv	e street and num	iber)	10-3		4b. City, Town, or I	ocation of Deetl	4c. County	of Death	
	V	ILLA OF	ST MICH	AELS			BALTIM	ORE		N	/A
	5. Social Security Nu 069-12-	7736	Sex 1 M 2 F	7. Age (In yrs. Ia. 91	st birthday) Yrs.	Months Days		8. Date of Bir Month De	1969	9. Births	olece (State or Fore
-	Usual Residence of to 10a. State	10b. County		10c. City.	Town or Loca	ation				1	Od. Inside City Lin
. 1	MD		N/A	100. 01.	1000101200	BALTIMO	RE				17☐ Yes 2☐
Director	10e. Street and Num	has				10f. Zip Code			10g. Citizen of N	After Cour	**
5			ITE				116			SA	mry r
E -	607 CLAYM	UNI AVEN		dent Ever in U.S	12 W	212		pacifu Vac or No			cen Indian,
2	1 ☐ Never Marrie 3 ☑ Widowed 4		Armed Ford 1 Yes If Yes, Give Year or Da	ces? 21 No		Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puert Specify:	Rican, etc.)	Specify	ck, White,	etc.
9		15. Decedent's E			16a. Decede	ent's Usual Occu	pation	U.	16b. Kind of B	usiness/In	dustry
Completed	(Specification (Speci	y only highest gra	completed) College (1-	40r 5+)		O NOT use retir	e during most of wor ed)	king			
E	8	oary (o-12)	Oonogo (1-	401 047	CUSTO	DIAN			CLEANING FIRM		RM
99	17. Father's Name (F	First, Middle, Last)				18. Mother's Nan			ne)	ASST CON
0	WILLIAM	MCCURE					NANNIE	WRIGHT			
	19a. Informant's Nar LULA COMM						ot and Number or Ru NT AVE. E				Code)
2	20a. Method of Dispo			0.00		ition (Name of	naal l	Date	20c. Location -	City or To	own, Stete
		Cremation 3		iate		atory or other pl	ace)	6/5/2000 BALTIMORE, MD			
	21 Senature of Funeral Service Licensee 22. Neme and Address of Facility										
	6 17.	4 0	2/12	In	JAN	MES A. I	MORTON & S	SONS F.H	I., INC		
4	23a Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heert failure. List only one cause on each line. Approximete Interval Between										
Examiner											
Nwed	cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in deeth) Last Due to (or es a consequence of): d										
S F	Part il. Other signific	cant conditions	contributing to dea	ath but not result	ting in the und	derivino cause o	iven in Pert I.	23b. Did	tobacco usa co	ntributs t	o the causa of d
by Physicia	1	TIPLE	1	CUBITI			1 Yes 2 No 3				bebly 42 Unit
Completed b				NEW Y					an eutopsy ormed?	av	ere autopsy findi reileble prior to empletion of caus death?
E								10	Yes 2000	1	Yes 2010
	25. Was case referre	ed termedical					26 Diseas of Day				200 400
0 '	exeminer?		Hospitai:	notion. OD-	D/Outreties	20 004 0	26. Place of Dea			nor (C	6.0
5 T	27. Manner of Death		28a. Date of	f Injury 2	R/Outpatient 28b. Time of				dence 8 Oth		191
Certification:	1 Natural 2 Accident 3 Suicide	5 Pending investigation	(Month	h, Day Year)	fnjury	M 1[ury at ork? □ Yes 2 □ No				-1.Pa 2/
	4 ☐ Homicide	determined	200. Place	of Injury - At homing, etc. (Specify)	ne, tarm, stre	et, factory, office		28f. Location (City or To	Street end Numl wn, State)	ver or Hur	ai Houle Numbei
	29e. Certifier (Check only one)	Certifying Ph	ysician: To the to niner: On the base	sis of examinetic	ledge, death on end/or inve	occurred at the estigetion, in my	time, date and place opinion, deeth occu	, and due to the rred at the time,	cause(s) and madate end place,	anner as s	stated. o the ceuse(s)
	29b. Signeture And ti	itie of certifier	A A	er stateu.		29c. Licer	nse number		29d. Date signe	d (Month.	Day, Year)
			Nal	00,000	e	7	a oras	-	5/31	00	,
	Aa	Meen				D	1900		3 31	00	
	3	em (AKHA	of deeth (Item 2	23a) (Type, P	PARIL	HEICH	73 A	YEI K	BAC	ra Mi
ite 3	31. Date filed (Month	n, Dey, Year)	32. Re	egistrer's Signetu	ire /						2120
trar	JUN 0 1 20	000 /	Geneval	19	Sport	2					,



	Certificate of L		R	leg. No. UU	17447					
/sician	1. Decedent's Name (First, Middle, Last)		2. Dete of Dea Month	Dey Ye	3. Time of Death					
ledical	Lena F. Angel		May	12 20						
aminer		4b. City, Town, or Lo	ocation of Death							
	St. Agnes Hospital	Baltim		N/						
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De)	y, Year) 9.	Birthplace (Stete or Foreign Country)					
	244 14 0333 82 113.		July 4,	1917	North Carolina					
	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location				10d Inside City Limits					
_					10d. Inside City Limits 1 ☑ Yas 2 ☐ No					
	Maryland N/A Baltimore									
Tallela Dilecto	10a. Street end Number 10f. Zip Code			10g. Citizen of Wha	it Country?					
	2102 Eagle Street 2122	23		U.S.						
	11. Merital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hi If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or No-	14. Race -	American Indian, White, etc.					
	1 Never Married 2 Married 1 Yes 2 1 No If Yes, Give 1 Yes, 2 1 No		11001, 010.7							
1	3€ Widowed 4 Divorced Year or Dates:	Specify.		Specify:	White					
Ì	15. Decedent's Education 16a. Decedent's Usual Occupa	ation	ina	16b. Kind of Busin	ess/Industry					
	(Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired. Elementary/Secondary (0-12) College (1-4or 5+)	d) most or work	rig .							
	11th Homemaker			Own	Home					
	17. Father's Neme (First, Middle, Last)	18. Mother's Name	a (First, Middle,	Meiden Surnema)						
	James Madison Middleton	Sa	vannah	Georgia S	Stewart					
	19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street a	and Number or Run	al Routa Numbe	r, City or Town, Ste	ite, Zip Code)					
	Beth Rogers 114 - 9th Ave	nue F	Baltimor	e. Marvla	and 21225					
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)			20c. Location - Cit						
	Lighten 2 Cremation 3 Hemoval from State		1000							
	4 Donetion 5 Other (Specify) Crestlawn Memoria	1	7 23/00	Marriotts	sville, Md.					
	21. Signature of Funeral Service Licensee 22. Name and Addres	ss of Fecility	Gonce F	uneral Ho	ome P.A.					
	Cerme Branche 4001 Ritch	ie Highwa	y Balt	imore, Mo	1. 21225					
	23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	ng, such es cardiac	or respiretory en	rest,	Approximate Interval Between					
	, on the same of t				Onset and Death					
	Immediate Cause (Final	1-0-			hours					
	resulting in death)									
	Due to (or as a consequence of): (/									
	Sequentially list conditions. Due to (or as a consequence of):		-		1					
	Sequentially list conditions, if any, leading to immediate									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):									
	resulting in death) Last Due to (or as a consequence of):									
to the same of the same	d									
	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Pert I.	23b. Did to		bute to the cause of death?					
	Lower GAStrointestinal bleed		1 U Y	□ Probably 4 ☑ Onknown						
				T						
			24a. Wes e perfor		4b. Ware autopsy findings aveilable prior to					
					completion of cause of death?					
			1 D Y	es 2 No	1 ☐ Yes 2 ☐ No					
	25. Was case referred to medical	26. Place of Deet	h (Check only or	ne)						
	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	or-		ence 6 □Othar	(Speciful					
ı	27. Manney of Death 28a. Date of Injury 28b. Time of 28c. Injury			ow injury occurred	<i>эрвспу</i> ј					
	AA 401	k? Yes 2 □ No		,						
	3 Suicide 8 Could not be		29f Location /S	treat and Number	or Rurel Route Number,					
	4 Homicide determined building, etc. (Specify)		City or Tow	n, Stete)	or Francis Francis					
	29e. Certifier (Check only (ne, date and place, pinion, death occur	end due to the o red et the time, o	euse(s) and menn- late end plece, and	er as stated. I due to the ceuse(s)					
	one) and manner stated.									
	29b. Signature and title of certifier 29c. License	1		29d. Dete signed (A						
	Elm Jaloha no P13	3594		May 2	2 2000					
	30. Name and address of person who completed cause of death (flem 23a) (Type, Print)		0	11	2, 2000 MD 21229					
	Tom Balshi St. Agnes Hospital 9000	aton Ave	1Sa1	timore	MD 21229					
,	31. Date filed (Month, Day, Year) 32 Registrar's Signature				1					
	JUN 0 1 2000 Source & Sparks									
4										

State of Maryland / Department of Health and Mental Hygiene 00 1741

					Cert	ificate of	Death		Reg. No.		1448
		t. Decedent's Name (First, Middle, La	st)					2. Date of Dec		Year	3. Time of Death
Physic /Medi		Angelo A. Ag	n					05		0	9:25P
Exami		4a Facility Name (If not institution, give			1/-		4b. City, Town, o	r Location of Death		of Death	
52 II.		University of Mayle	and Medica	el Sysi	lem		Balhme	re	NY	A	
Funeral Director		5. Social Security Number 6. 9 215-01-4242	7. Age	(In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days			h y, Year)		place (State or Foreign intry) aryland
P		Usual Residence of Decedent									
the Marylar 28a-f show		10a. State 10b. County	3-1	10c. City, To							10d. Inside City Limits
M -	cto	Maryland Anne Ar	undel	Gre	n Bur	nie					1 ☐ Yes 2% No
5-0020 72 hours after deeth with the Manyland neturel', or items 23s or 28s-f show deet Exercise and a second seco	ai Director	100. Street and Number 1006 - 1st Street	et			10f. Zip Code 210	60		10g. Citizen of V U.S		ntry?
ter dee items	Funerai	11, Maritai Status	12. Was Decedent E Armed Forces?	ver in U,S.	13. W	as Decedent of Yes, specify Cul	Hispanic Origin? (pan, Mexicen, Pue	Specify Yes or No		e - Ameri	ican indien,
21215-0020 d within 72 hours after giene. The fractural, or it.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1∑ Yes 2 N If Yes, Give Year or Dates:	lo		JYes 2⊠No			Specify		hite
5-0 72 ho	Completed	15. Decedent's E (Specify only highest gro		16	Se. Decede	nt's Usual Occu	pation	odkina	16b. Kind of Bu	siness/Ir	ndustry
T C 1 8	ple	Elementery/Secondary (0-12)	College (1-4or 5-	+)	life. Do	NOT use retir	during most of w	Orking			
	ő		4 years		Sale	esman			Self H	implo	oyed
bra file file other	Be (17. Father's Name (First, Middle, Last)					ame (First, Middle,			
Vent Vent rked ttc e	10	J	ohn Agro				I	Florence	Conciato	ore	
		19a. Informant's Name/Relationship (Type, Print)	15	9b. Mailing	Address (Stree	t and Number or I	Rural Route Numbe	er, City or Town,	State, Zij	p Code)
e, Marith a Health a em 27 is		Dolores Agro /	Wife	1	1006	- 1st S	treet	Glen Bu	rnie, M	aryl	and 21060
0 80 2 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		ceme	tery, crema	tion (Name of atory or other pl		Date 6/2/00	20c. Location - Baltimo:		own, Stete Maryland
Baltimosemit. Peg Department Important: I any injury o		21. Signature of Funeral Service Lice		Ducz		Name and Addi			uneral 1		
Balt permit. Departu importa any inje		Decome for	amerous	ch.			A	way Balt			
221 - 1		23 Part 1. Enter the disease, or com- shock, or heart tailure. List only	plications that caused one cause on each lin	the death. D	o not enler	the mode of dy	ing, such as cerdi	ac or respiretory a	rest,		Approximete Interval Between
Physician					,					1	Onset and Death
/Medical		Immediate Causa (Final disease or condition	a. Arrhy	ythmi	9						
Examiner		resulting In death)	8.	Due to (or as	a consequ	ence of):				- 1	
R :	ine		Ische	mic C	avelo	wholu	My			i	
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate		Due to (or as	a consequ	ence of):					
So, se ex		cause. Enter Underlying Cause (Disease or Injury	Corono	m ar	teng	Discer	e				
68760, ficate be ex physician	Medical	that initiated events resulting in death) Last		Due to (or as	a conseque	ence of):	575-1-1				
K 66	Me										
Box eath cert attendin for use	an		d							1	
O. B. of the at the at fred for	Physician	Part ii. Other eignificant conditions of	contributing to death bu	t not resulting	g in the und	derlying cause g	iven in Pert i.	23b. Did	lobacco uae cor	ntributa 1	to the cause of death?
P.O. that the ded by the detached	Phy							10	Y00 3000	3 Pro	obably 4 Unknown
w requires that been signed to should be det											
Division of Vital Records, to attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed by							24a. Was	an autopsy	a	Vere autopsy findings vailable prior to
s be	pie									O	ompletion of cause it death?
Re ha iav	E							10	Yes 22 No	1	□Yes 2□No
f Vital Riysician: That is certificate he director, page		25. Was case referred to medical					26 Piace of D	eath (Check only o			
of Vita Physician: rthis certific	To Be	examiner?	Hospitel:	ot 2∏ED#	Outpationt	3 DOA	thor	Home 5 Resi		er /Snec	16.1
Phys arthris		27. Manner of Death	28a. Date of Injur	y 28t	o. Time of	28c. Inj			how injury occur		1177
On Offing	흔	1 Natural 5 Pending investigation	(Month, Day	Year)	Injury		ork? ⊒Yes 2 ⊒No				
Vision Attending or death. ector: After by the fune	Ca	3 ☐ Suicide 6 ☐ Could not b	e Diago of inju	Inv - At home	farm stree			28f. Location (Street and Numb	er or Ru	ral Route Number,
Or A street in by	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	tarm, street	or, rectory, ornor		City or To	vn, State)		
letal use a series		00-0-17							1.582,30		
Division or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai		nysician: To the best of miner: On the basis of end menner sta	examination a							
To the To the Comp	Σ	29b. Signature and title of certifier				29c. Licer	se number		29d. Date signe	d (Month	, Day, Year)
		Dollat hu	NA			PS	13365		05/29	1/00	
1		30. Name and eddress of person who	completed cause of de	ath (item 23s	a) (Type P	rint)					
O.	110	Jolene Brown MD			zene	Street	2/2	10			
Sta	ato.	31. Date filed (Month, Day, Year)		er's Signature		1	,				1 1 1 1 1 1 1 1
Regist		JUN 0 1	. /	pera	19	spa	eks				



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** theein .05 pm /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex 2726 Shalon 5. Social Security Number 6 Harford If Linder 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1□ M 21 F 64 220-30-5445 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 25s-f show with the Maryl 1 Yes 2 No Funeral Director the Medical Examiner must be notifi-10f Zin Code 10g. Citizen of What Country? 10e Street and Number 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) . Was Decedent Ever in U,S Armed Forces? Race - American Black, White, etc. American Indian 11. Marital Status hours after 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Merried 2 Married b Maryland 21215-0020 1 Yes 25 No Specify Specity: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be tiled within 72 nent of Health and Mental Hygiene. GORDON Finebalt Health and Mental Hygiene. Inn 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be To 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Q Department of Health a Important: If Item 27 is any injury or other tra Shalpn athloon Baltimore, 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location -1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) and Address of Facility 21. Signature of Furieral Service Licenses T. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or control failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 2 month Cancer disease or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last the bunal-tran Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buna Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 ☐ Yes 20 No 3 Probably 4 Unknown Completed by Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has 20 No 1 ☐ Yes 2 No or Attanding Physician: director. 25. Was case referred to medical exeminer? daughtees 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 8 Sother (Specify) 1 Yes 2 No Monus 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 TYes 2 TNo death. I Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide after To the Hospital o within 24 hours at To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

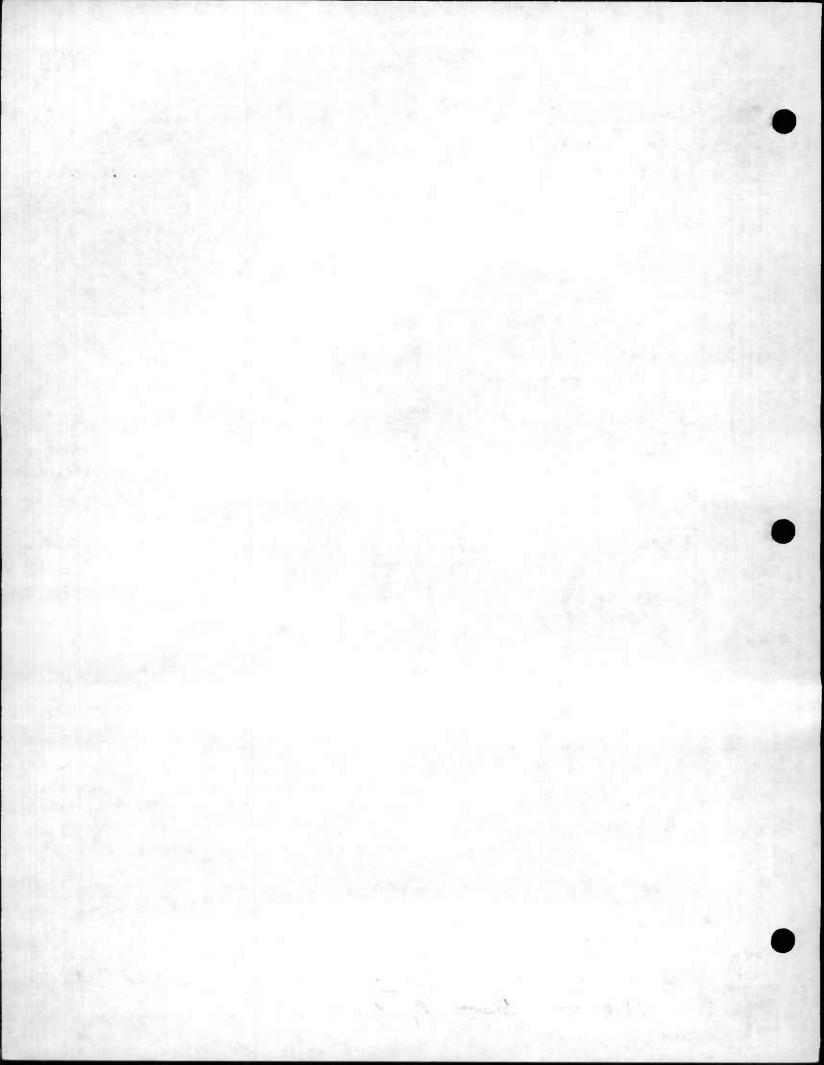
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier D1531 ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 31. Date filed (Month, Day, Year) --32 Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

2000

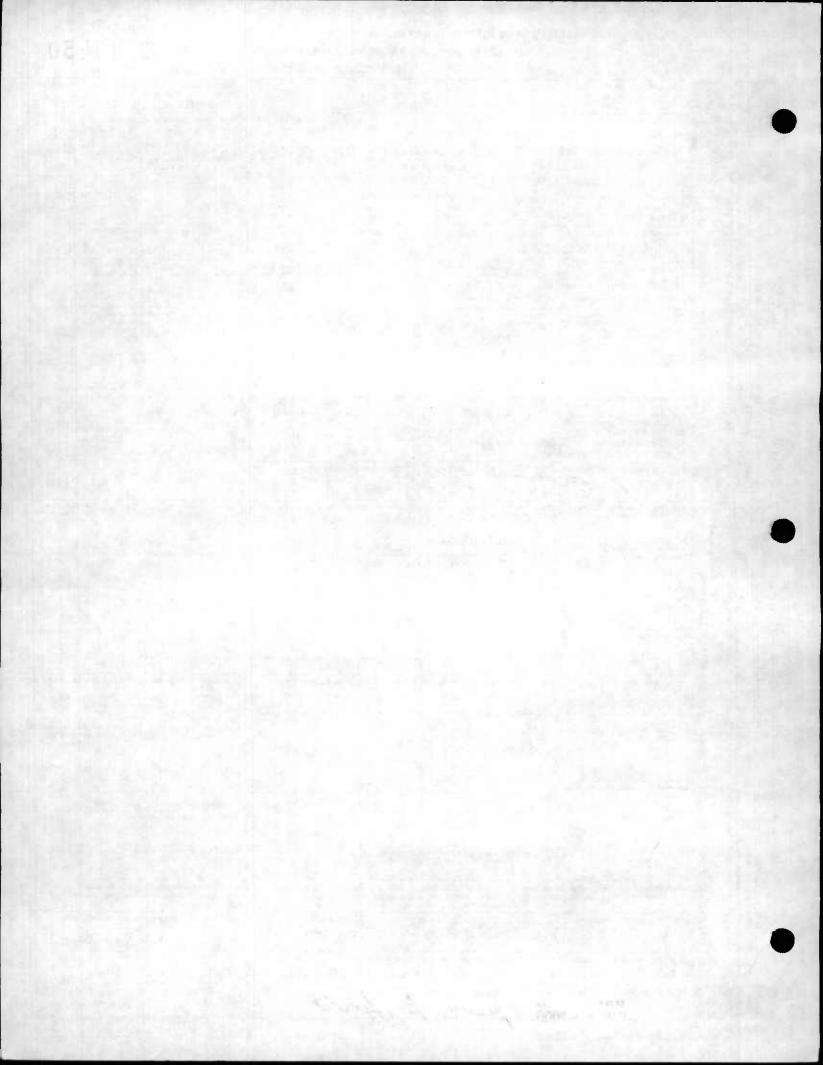
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 0 0 17450

Certificate of Death

not institution, give Joseph mber 6. Se 10 Decedent 10b. County Baltimor ber andrake Re ad 20 Married 1 Divorced 15. Decedent's Edu y only highest grad dary (0-12) and P. Bor me/Raiationship (7) Evans /	rman Bornhor street and number) Medical Ce xx 7. Age (In yr AM 2DF 10c. (Control of the control of the completed) Collega (1-4 or 5+) 2	enter s. last birthday) 94 Yrs. City, Town or Loc Riderwo	cation OOd 10f. Zip Co- 2 Was Decedent f Yes, specify 1 Yes 2	da 1204 of Hispanic Origin? Duban, Mexicen, Pue	r Location of Dei	Day MAY 28, ath 4c. County lighth Pay, Year) 11, 1905	of Death Baltimore 9. Birthplace (State or Fore Country) Maryland 10d. Inside City L 1 Yes 2)		
mber 6. Se 17, 17, 18, 18, 18, 18, 18, 18, 18, 18, 18, 18	Medical Ce X M 2DF 7. Age (In yr 10c. (12. Was Decedent Ever in Armed Forces? 1 Yes, Give Year or Dates: Jucation 1/2 (completed) Collega (1-4or 5+) 2	S. lest birthday) 94 Yrs. City, Town or Loc RiderW U.S. 13. V	cation OOd 10f. Zip Coc 2 Was Decedent t Yes, specify 1 Yes 2 Yes 2 Yes 2	da 1 20 4 of Hispanic Origin?	8. Date of E (Month, I NOV.	Sirth Year) 11, 1905 10g. Cilizen of V	9. Birthplace (State or Forecountry) Maryland 10d. Inside City L 1 Yes 2) What Country? ced States		
mber 6. Se 178 100-County Baltimor ber andrake Ri d 201 Married 1 Divorced 15. Decedent's Edity only highest gradidary (0-12) The P. Bor me/Raiationship (7) Evans /	7. Age (in yr (i	S. lest birthday) 94 Yrs. City, Town or Loc RiderW U.S. 13. V	cation OOd 10f. Zip Coc 2 Was Decedent t Yes, specify 1 Yes 2X1	da 1204 of Hispanic Origin? Duban, Mexicen, Pue	s. 8. Data of E. (Month, I. NOV.	11, 1905 10g. Cilizen of V Unit	9. Birthplace (State or Fo		
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andrake Rind a 2 Married a Divorced 15. Decedent's Edity only highest gradidary (0-12) First, Middle, Last) Cd P. Borme/Raiationship (7) Evans /	Odd 12. Was Decedent Ever in Armed Forces? 1	U,S. 13. V	10f. Zip Cod 2 Was Decedent f Yes, specify	1204 of Hispanic Origin? Cuban, Mexicen, Pue	Specify Yes or I	Unit	What Country?		
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IDIVorced 15. Decedent's Educy only highest grad dary (0-12) First, Middle, Last) Cd P. Bor me/Ralationship (T) Evans /	Armed Forces? 1 Yes 2 Xe 2 Yes 1 Yes 2 Xe 1 Yes 2 Xe 1 Yes 2 Xe 2 Yes 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 3 1 Yes 4 1 Yes 4 1 Yes 5 1 Yes 6 1 Yes 6 1 Yes 6 1 Yes 7 1	16a Deced	I□Yes 2X		Specify Yes or I	No- 14. Rac	e - American Indian.		
IDIVorced 15. Decedent's Educy only highest grad dary (0-12) First, Middle, Last) Cd P. Bor me/Ralationship (T) Evans /	1 Yes 2 No If Yes, Give Year or Dates: June 2 Year or Dates: June 2 Year or Dates: June 2 Yes Yes College (1-4or 5+) 2	16a Deced	I□Yes 2X				ck, White, etc.		
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First, Middle, Last) d P. Bor me/Ralationship (7) Evans /	2	1170. E	lent's Usual O kind of work d OO NOT use n	ccupation one during most of w tired)	orking	usiness/Industry			
rd P. Bor me/Raiationship (7) Evans /	PERMIT	Elementary/Secondary (0-12) Collega (1-4or 5+)							
me/Raiationship (7) Evans /	a braner		neceui		ame (First, Midd	la, Maiden Sumen	Electric		
Evans /	nnorn			Anna	Rott				
	ype, Print)	19b. Mailin	ng Address (St	reat and Number or	Pural Route Num	nber, City or Town,	Stata, Zip Code)		
4.1				ing Woods	Road B	Baltimore	e, MD 21234		
osition	20b Removal from Stata	. Place of Disposemetery, cren	sition (Name onetony or other	f place)	Daie	20c. Location -	- City or Town, Stata		
5 Other (Specify)	G	ardens d	of Fait	h Cem.	5/31/200	00 Balt	timore, Mary		
eral Service Licens	Michael Canar	op 22	. Nama and A	dress of Facility		5305 Har	rford Road		
ide	· Cayl.		LEONAR	D J. RUCK	. Inc.				
failura. List only o	lications that caused the de one cause on each line.	atii. Do not enti	ar (ria mode or	dying, such as cerd	ac or respiratory	arrest,	Approximata Interval Betwee Onset end Dea		
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disease or condition resulting in death) Dua to (or as a consequence of):									
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ant conditions co	ntributing to death but not re	esulting in the ur	ndarlving caus	niven in Part I	23h Di	d tohacco use co	ontribute to the cause of d		
TION	And any to down but not in	ooditing in the di	idanying dada	giron arr dit i.			3 Probably 4 ⊞ Un		
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ONISM						as an autopsy rformed?	24b. Were autopsy find available prior to		
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ed to medicel		74			eath (Check onl	y ona)			
10		☐ ER/Outpatien			· · · · · · · · · · · · · · · · · · ·	sidence 6 DOth			
5 Pending	28a. Data of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	28d. Describ	e how injury occur	rred		
6 ☐ Could not be	28a Place of trium - At	home form str			28f Location	Street and Numi	her or Rural Routa Numbe		
detarmined	building, atc. (Spe	city)	eet, factory, or	100	City or 1	Town, State)			
,	etclan: To the best of my k	nowledge, death	occurred at the	e time, data and pla	ce, and due to th	na ceuse(s) and m	anner as stated.		
Certifying Phy	ner: On the basis of exami end manner stated.	nation and/or inv	astigation, in	ny opinion, daath oc	curred at tha tim	e, data end place,	and dua to the causa(s)		
1 ☑ Certifying Phy	1 -		29c. Li	ense number	1.187.7	29d. Date signe	ed (Month, Dey, Year)		
Certifying Phy	me c	na	DB	7254		5-	31-00		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 29b per Dr 6/8/00dhb G784 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 33 30 may ETHEL BOBO aa2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner mercy medical Center Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplace (Steta or Foreign Country) 6. Sax 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 20 F Yrs. 214-05-7890 Director 84 July 2, 1915 Maryland Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shor 1□ Yas 21 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 23a 3161 Baybriar Road 21222 Funeral United States 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2☐No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status Sied within 72 hours after 1 Naver Marriad 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Ves Give Specify. 2 White 3 Nidowed 4 Divorced Yaar or Detas: Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Ages 1 and 2 should be fill out of Health and Mental Hi ft. If Hern 27 is marked oth y or other traumatic event Be Charles Burton Lowery Hazel Fier 19a. Informant's Neme/Raiationship (Type, Print) (Daughter) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Broadship Road Dundalk, Maryland 21222 Mrs. Carol Jean Butrim Pages 1 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Crametion 3 □ Ramovel from Stete Department of Important: If any injury or one 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 6/3/2000 Dorsey, Maryland 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Tail the cisaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heady allum. Approximata Interval Between Onset end Death **Physician** Immediata Causa (Final diseasa or condition rasulting in daath) /Medical ear **Examiner** Dua to (or as a consequence of Physician/Medical Examiner sician and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, laeding to immediata causa. Entar Undarlying Cause (Disaase or Injury Dua to (or as a consequence of): inding physician use as the bunal Box 68760. that initiated avents rasulting in death) Last Dua to (or as a consequence of) jo signed by the a P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. P 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital Attending Physician: Be 25. Was casa rafarred to medical examinar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Nospice 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA r death. Medical Certification: To 28c. Injury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1. Netural 1 Yas 2 No Hospital or Attendi
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Division To the Hospital of within 24 hours at To the Funeral D completely filled in

DHMH 16 Rev 6/95

State Registrar 29a. Certifiar

Im, MD Dwight 31. Data filed (Month, Day, Year) JUN 0 1 2000

29b. Signatore and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3015t. Paul Place Paltimore, MD 32. Registrar's Signature

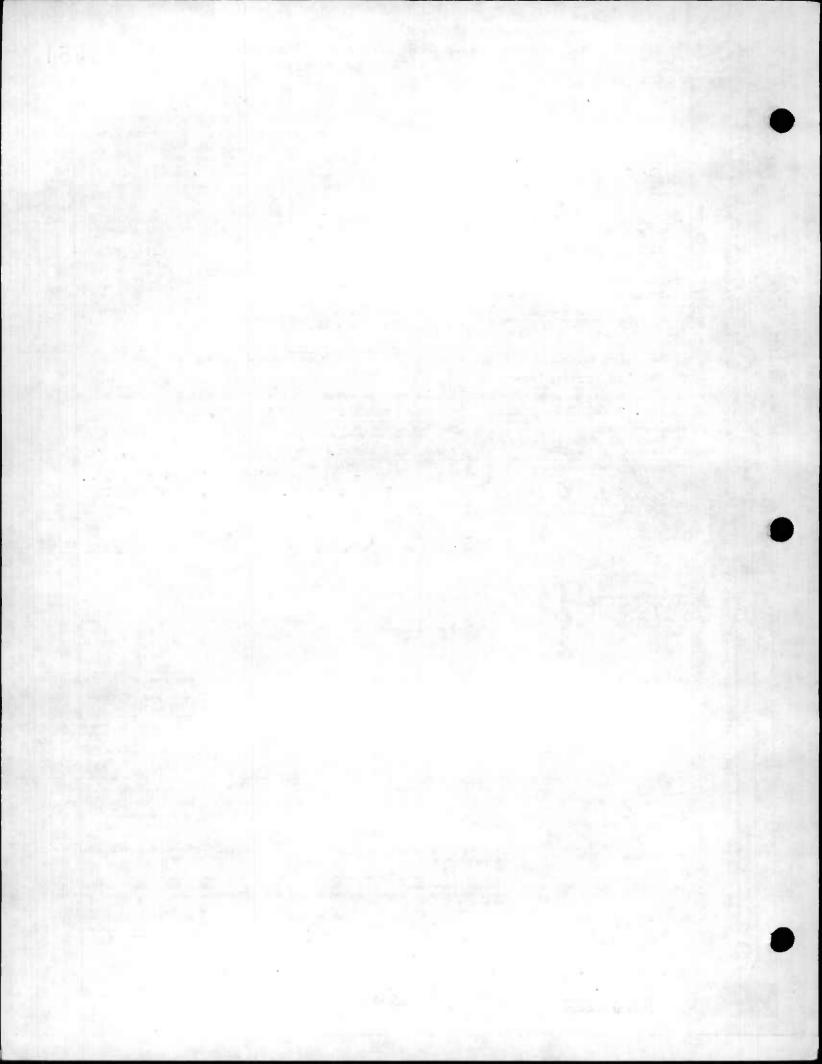
1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

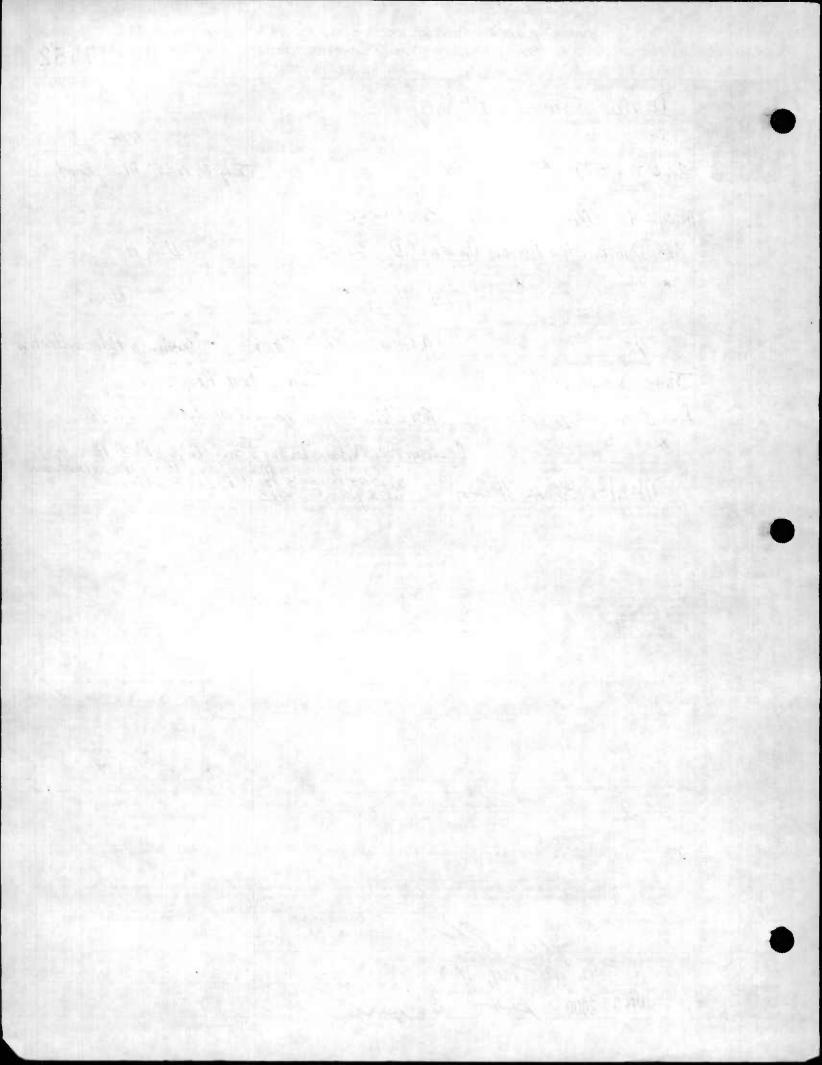
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BaHimore 4a, Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner IVERVICE SSEX ent er Hours Min. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign Country)
Pennsylvania **Funeral** 1 □ M 2 0 F Months Davs 064200162 October 05 1917 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Show r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director Maryland Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "E" Glenshanon Court 21221 U.S.A. Funeral 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black White etc. 1 Nevar Married 200 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Yes 2XXIIo Specify: þ 3 Wildowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mantal Hygiene Important: if itam 27 is marked other tha any fijury or other traumatic event, and once. Factory Worker Factory 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be John Siranko unk. 0 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 6"E" Glenshanon Court, Baltimore, Maryland 21221 Michael Bobrik (husband) 20b. Place of Disposition (Name of cametery, cremetory or other piece, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery 5/29/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21 Signature of Furie (al Se VIS) Licensee 22. Neme and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Don't En of the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, book, or heart failure. List only one causa on each line. Approximete Interval Batween Onset and Death Physic an Immediate Cause (Final disease or condition resulting in death) /wedical Ettantin ar Due to (or as e consequence of): buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): Physician/Medical that initiated events resulting In death) Lest the Due to (or as a consequence of) as esn for Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 | Yes 2 | No 3 Probably 4 Unknown þ 8 24b. Wera autopsy findings eveileble prior to Completed 24a. Was an autopsy completion of cause of death? pege 2 1 Tes 2 W.No director Be 25. Was cese raferred to medical examiner? 26. Placa of Daath (Check only ona) Other: 4 Whursing Homa 5 - Residence 6 - Other (Specify) Certification: To 1 Yes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

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Baltimore, Maryland 21215-0020

28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 1 Natural
2 Accident 5 Panding investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Cartifier 1 Cartifying Physician: To the bast of my knowledge, daath occurred at tha time, date and piaca, and due to tha causa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha time, date and piaca, and due to the cause(s) end manner stated.

29b. Signature and title of certified

JUN 0 1 2000

29c. License number more

29d. Date signed (Month, Day, Year) 2000

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Sireesh Tripuraneni, 5601 Loch Raven Blvd., Baltimore, Maryland 21239 31. Date filed (Month, Day, Year)

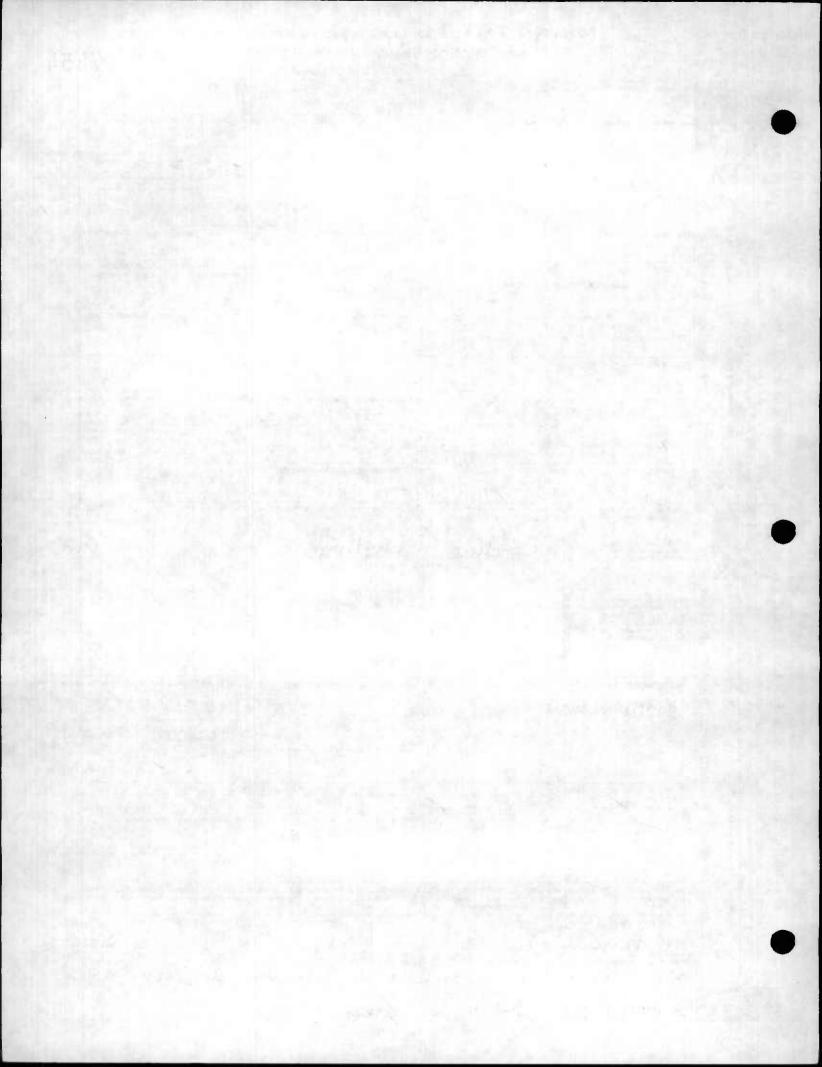
Registrar

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32. Registrar's Signature

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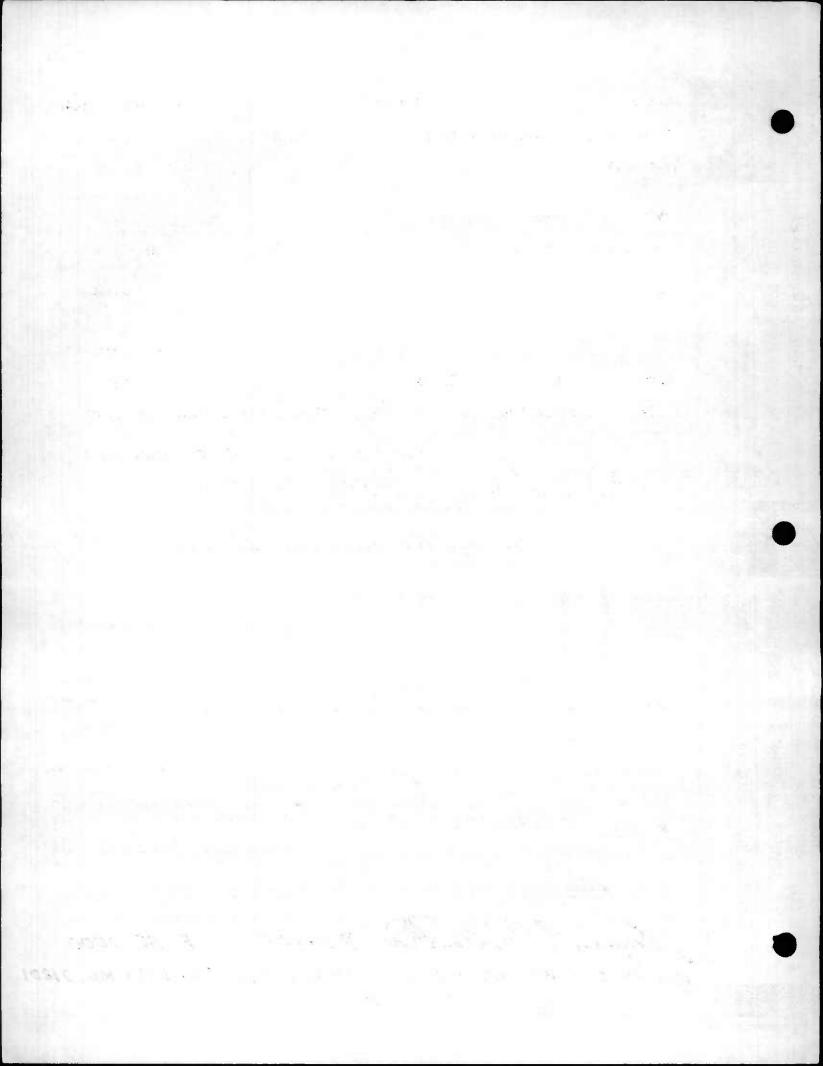
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Funeral Director		5. Social Security Number 218–18–2427	6. Sex 1 □ M 2 ☑ F	7. Age (In yrs. la	st birthday) Yrs.			if Under 2 Hours	4 Hrs. 8. Date o	Birth Day, Yea 2 192	??) !3	9. Birthp Cour a COM	lace (State or Foreign try) a Washingt
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Semit. Pages 1 and Department of Health important: if item 27 iny injury or other tr alice.		Kathleen L. Sha 20a. Method of Disposition 1 Burlai 2 Cremation 4 Donation 5 Other (21. Signeture of Funeral Service 23a. Pert1. Enter the disease, shock, or heart feliure. List	3 □Removal from Si Specify)	20b. Pla cer Man	yland	vetera Neme and A	ns (Cernet	1 Home D	20c.	Location -	chy or To	wn, Stete
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Sta	te	M. Name and didress of person GREGORID M 31. Date filed (Month, Day, Year	BELLOS		;530		NAC	BERK	RY DR.,	SALIS	BUR	Y, M	D, 2180

Registrar

JUN 0 1 2000

Fotus Brumwell



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 28 **Physician** 2000 4:35AM May Louise /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) UNK . 192 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** Months Days 1 M 2 N F North Carolina 219-22-3252 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow natural, or items 23a or 28a-f ahor olgai Examiner must be nottiled at 1 ☐ Yes 2 X No Director Crownsville MD Anne Arundel 10f Zin Code 10g. Citizen of What Country? 10e Street and Number 21032 USA 1520 Crownsville Road death Funeral 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Introductur: If them 27 Is marked other than "natural; or the any injury or other traumatic avant, The Medical Essentin 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p B1ack 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Never Worked Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Burn Fred **Black** 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Guardian of Person) 301 West Preston St. Baltimore, Md. 21201 John C. Coe 20b. Place of Disposition (Name of cemetery, crematory or other place) Dele 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/1/00 Baltimore, MD Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22 Neme and Address of Facility
Stallings Funeral Home P.A. 21. Signeture of Funeral Service Liver 3111 Mountain Road Pasadena, MD 21122 s that tailsed the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Part1. Enter the disease, or compleanock, or heart failure. List only o Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence ol): Examiner physician and the bunal-trensit that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 98 for use 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee NO 3 Probably 4 Unknown Records. þ sign s The lew requires 24b. Were autopsy lindings eveilable prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 2 000 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Suppatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To this 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOORE Anne Co

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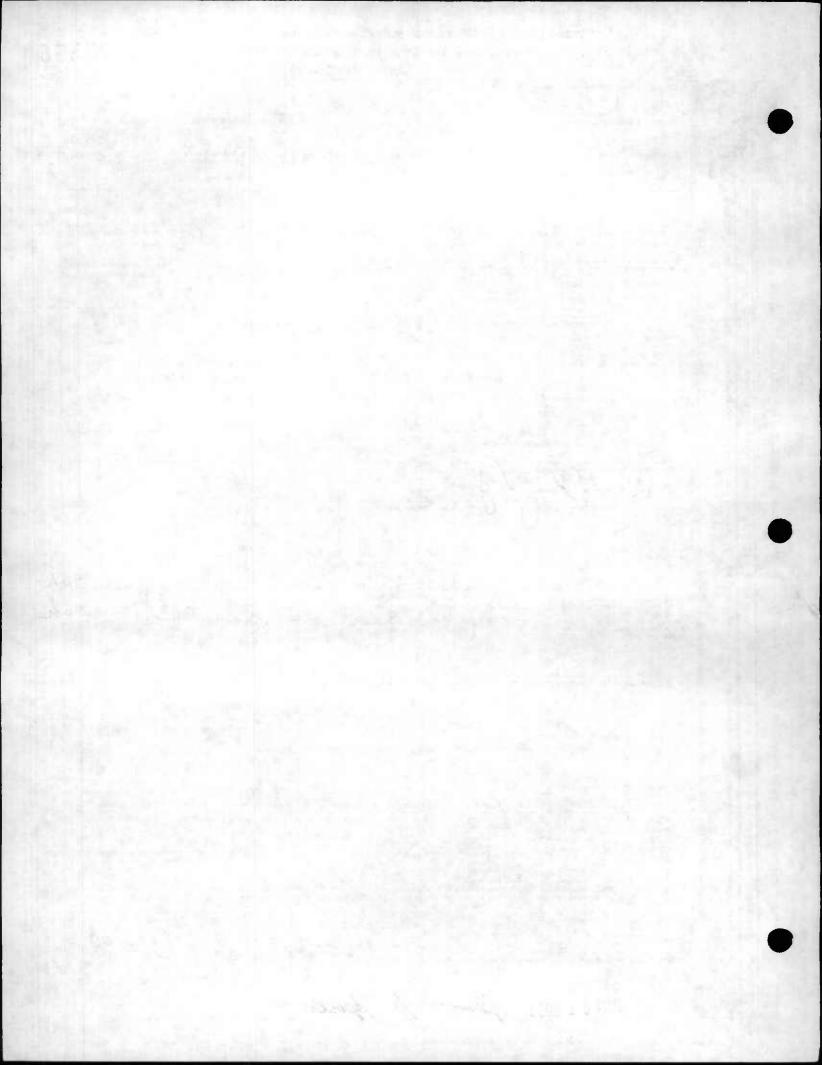
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Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 00-2862-510 State of Maryland / Department of Health and Mental Hygiene Edwin Brim Certificate of Death JVW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 22, 2000 **Physician** Edwin Arnold Brim 11:40 A.M. °/Medical 4c. County of Deeth N/A 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Baltimore 2712 Hugo Avenue 9. Birthplace (State or Foreign Country)
Maryland If Under 24 Hrs. If Under 1 Year APR 10, 1958 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 215-70-3897 1 M 2 F 42 Yrs Director Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelth and Mental Hyglene. Important: if Itam 27 is merical other than "natural", or Nerm 23s and natural any Injury or other traumation. 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1√2 Yes 2 □ No Maryland N/A Funeral Directo Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2712 Hugo Avenue 21218 USA 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Never Married 2 Married Yes 2V No 1 Yes ZONO Specify: Black Baltimore, Maryland 21215-0020 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Designer 12 Engineering Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Roy Brim Doris Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1763 Abbotston St. Baltimore, MD 21218 ca of Disposition (Name of Dete 20c. Location - City or Town, State Davon Brim/Son 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 5/31/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Urcensee Cremation Society of Maryland, Inc. Edward A Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Pontine Hemorrhage Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last burial-tran pue Due to (or as a consequenca of): Box 68760. ettending physician Physician/Medical the Due to (or as a consequence of) 9 use i P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown of Vital Records, ð 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen page 2 After this certificate has 1 MYes 2 □ No 12 Yes 2 No is or Attending Physician: The safer deeth.

By Director: After this certificated in by the funeral director, pi Be 25. Was case referred to medical 26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Xes 2 □ No Scene Medicai Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piaca, and due to the cause(s) and menner as stated.

**EXPAGGICAL Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified O.C.M.E. May 23,2000 buten Vonne

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Registrar

Jennis J.

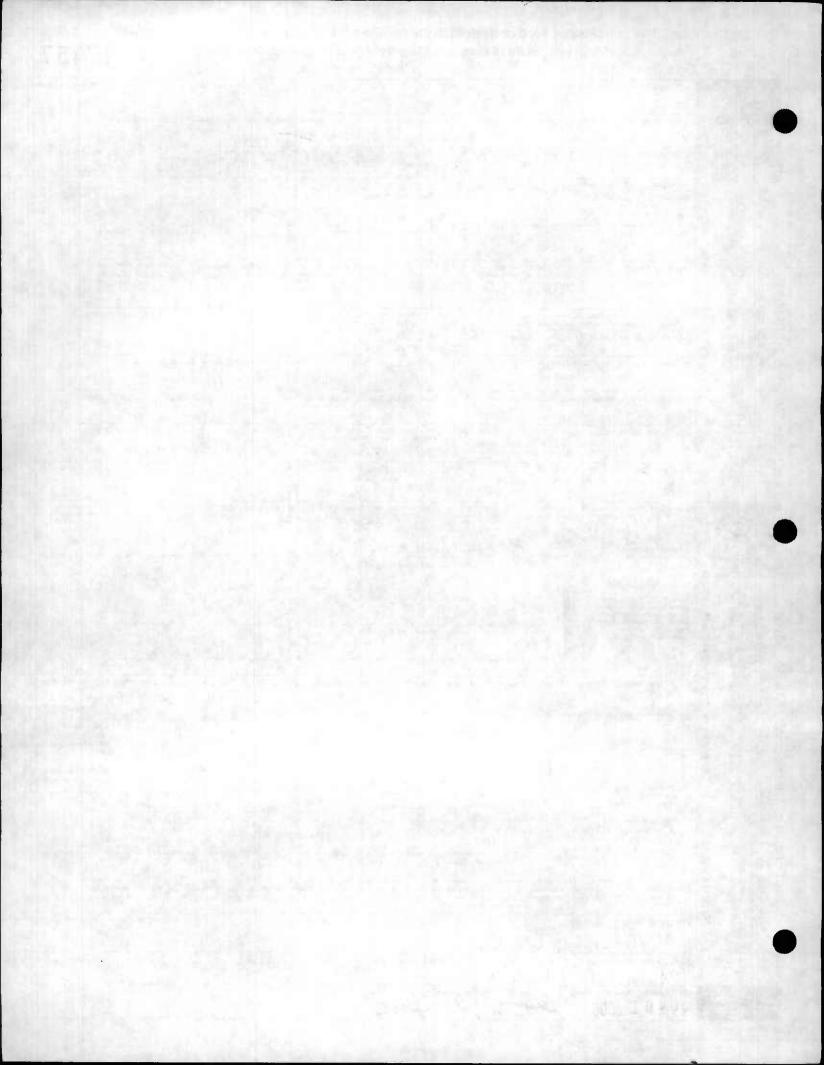
31. Date filed (Month, Day, Year)

JUN 0 1 2000

Seneral Signature Sparks

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Pin) 1 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** POLINA MAY 28, BRAVER 2000 12:00PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year, Birthplace (Stete or Foreign Country) **Funeral** Days Months Hours 1□ M 200 F 214-94-2266 86 SEPT.2,1913 Director UKRAINE Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No MD BALTIMORE BALTIMORE Funeral Director 28a-f the Medical Examiner must be notif 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? herna 23a or 6614 EDENVALE ROAD 21209 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Merried 1 Yes 2 No ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: WHITE à Specify. 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS GARMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o BEN SOKOLINSKY RAIZEL KNYAJANSKY 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) SLAVA ZASLOV / DAUGHTER 6614 EDENVALE ROAD - BALTIMORE, MD 21209 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ♥ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 5/29/00 REISTERSTOWN, MD 21. Signature of Funeral Service Libenses 22. Neme end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - P.1

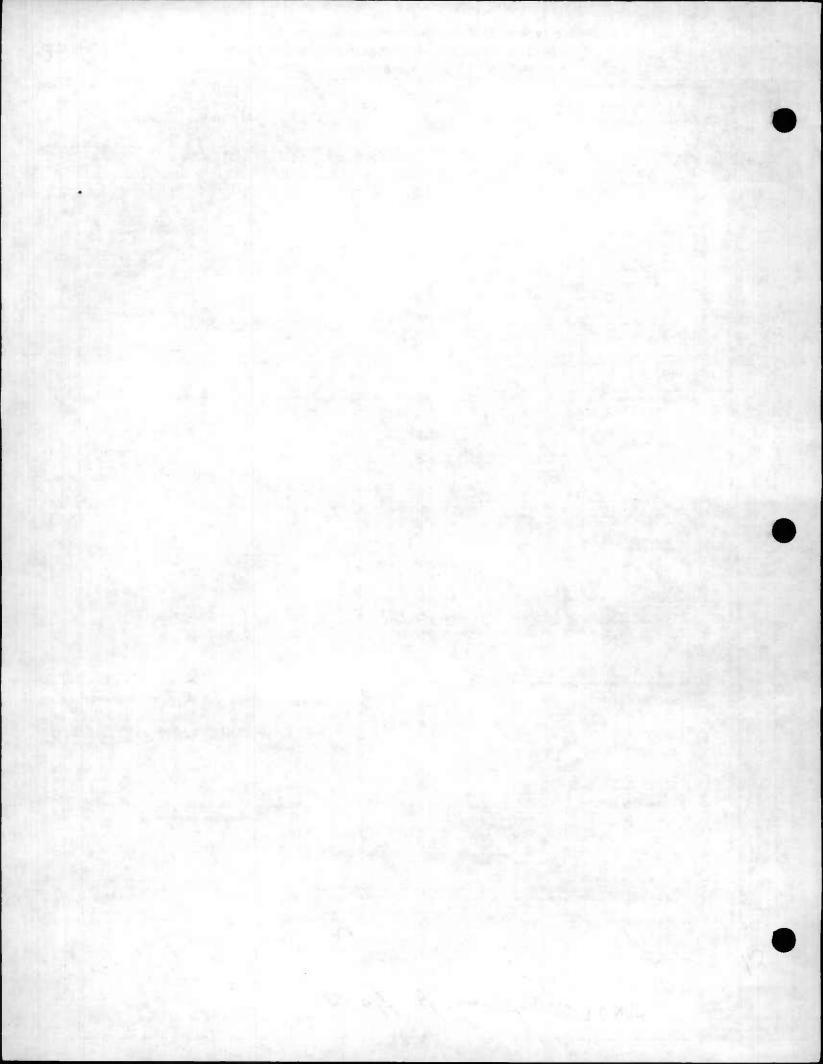
23a. Party Entenths disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate tnterval Between Onset and Death **Physician** tmmediate Cause (Finet disease or condition resulting in death) /Medical Foot Ganire Examiner Physician/Medical Examiner requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last use es the burial-trer androvascolar Discove of Vital Records, P.O. Box 68760, the attending physician revoscleron Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? director, page 2 should be detached 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Medical Certification: To Be Completed has 1 ☐ Yes 2 ☐ No 1 Yes After this certificate or Attending Physician: 25. Was case referred to medicet 26. Place of Death (Check only one) Hospital: Other: 4 Surrsing Home 5 Residence 6 Other (Specify) 1 Yes 200 1 | Inpatient 2 | ER/Outpatient 3 | DOA s after death.

I Director: After this of in by the funeral di 27. Mepner of Deeth 1 Of Vatural 2 Accident 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending Investigation Injury 1 Yes 2 No 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide within 24 hours a To the Funeral C Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manyler stated. 29a. Certifier completely i 29d. Date signed (Month, Day, Year) 29b. Signatura end title of certifie 29c. License number se of deeth (Item 23a) (Type 30. Name and eddress of person who completed 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 0 1 2000

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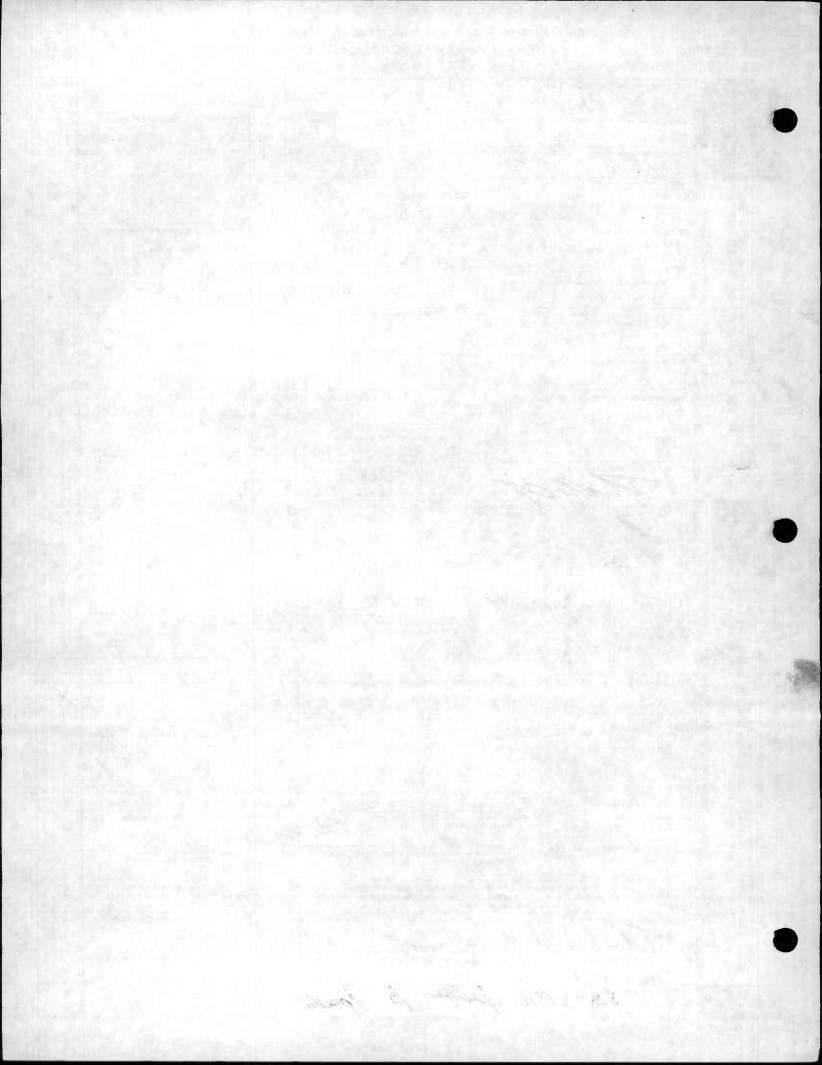
Braver, Follman



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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	414 BROOKS COURT			Willades 1 Va		BURNIE		INE ARU		
ral tor	5. Social Security Number 6. S 218-70-5978 Usual Residence of Decedent	7. Age (h	n yrs. last b	oirthday) If Under 1 Ye Yrs. Months Da		Min. 8. Date of B (Month, D	ay, Year)	9. Birth Cou	placa (State or Foreign Iland	
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Funeral Director	10e. Streef and Number 414 Brook Avenue			10f. Zip Cod 2106			U.S.	n of What Cou	untry?	
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T _o	Hunter F. Blackbu					othy May W	- 0			
	19a. Informant's Name/Relationship (1) Porothy M. Black!			9b. Mailing Address (Str. 18925 Falls				21074	ip Code)	
	20a. Method of Disposition		20b. Place	of Disposition (Name of		Data	-	tion - City or T	Town, State	
	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Haven Mem.		5/30/00	Glas	Runni	le, MD.	
	21. Signature of Funeral Service Licen		ocen			7 0 11	Del	i butin	e, mo.	
	-UM	11		Schumune	k tuner	al Home of Road, Be	Bel A	Wr, In	1C.	
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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#23 PRT. B&C PER MD. G784 6-1-2000 JAGertificate of Death Reg. No. 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** 1:30 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of 4c. County of Death Examiner WHITE BALTO CO. MARSH 132 BULLONWEOD If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplaca (Stata or Foreign Country)
 LLD 5. Social Security Number 7. Aga (In yrs. last birthday) 6 Sex **Funeral** 1 M 2 F Months Days 219-07-242 Usual Rasidanca of Decedant Yrs. Director 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yas 2 No Director WHITE MARSH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò filed within 72 hours after death with U.S.A r than "natural", or itema 23a the Madical Examiner must b 12452 TONWEOD 2/220 Funeral 12. Was Decedant Evar in U,S. Armed Forces?
1 Yas 2 No If Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Baca - Amarican Indian 11. Marital Status 1 Navar Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 □ Divorced WHITE Yaar or Datas 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) RESTURAUT 12 Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If Nem 27 is marked of -EORGE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If fem 27 is m any injury or other traum page. BUTTONWOOD -JUD LANE. BALTO HD. 21220 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 F 3 Ramoval from Stata 21. Signature of Portural Sarvice Licensas 22. Nama and Address of Facility 829 HUDSON ST BALTO 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediate Causa (Final disaase or condition rasulting In death) /Medical despirator Examiner Dua to (or as a consequence of): CEREBROVASCULAR ACCIDENT Physician/Medical Examiner Ira tion the burial-transit The law requires that the death certificate be assouted Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or Injury that initiated events rasulting in daath) Last pue Dua to (or as a consequence of) Box 68760. brovascula Dua to (or as a consequence of) P.O. I Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? page 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24b. Ware autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1□ Yes 2N No 19ar ette 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician:
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| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certify

31. Data filed (Month, Day, Year)

arol A. Newill MD

JUN 0 1

2000

DHMH 16 Rev 6/95

To the

who completed causa of death (Item 23a) (Type, Print)

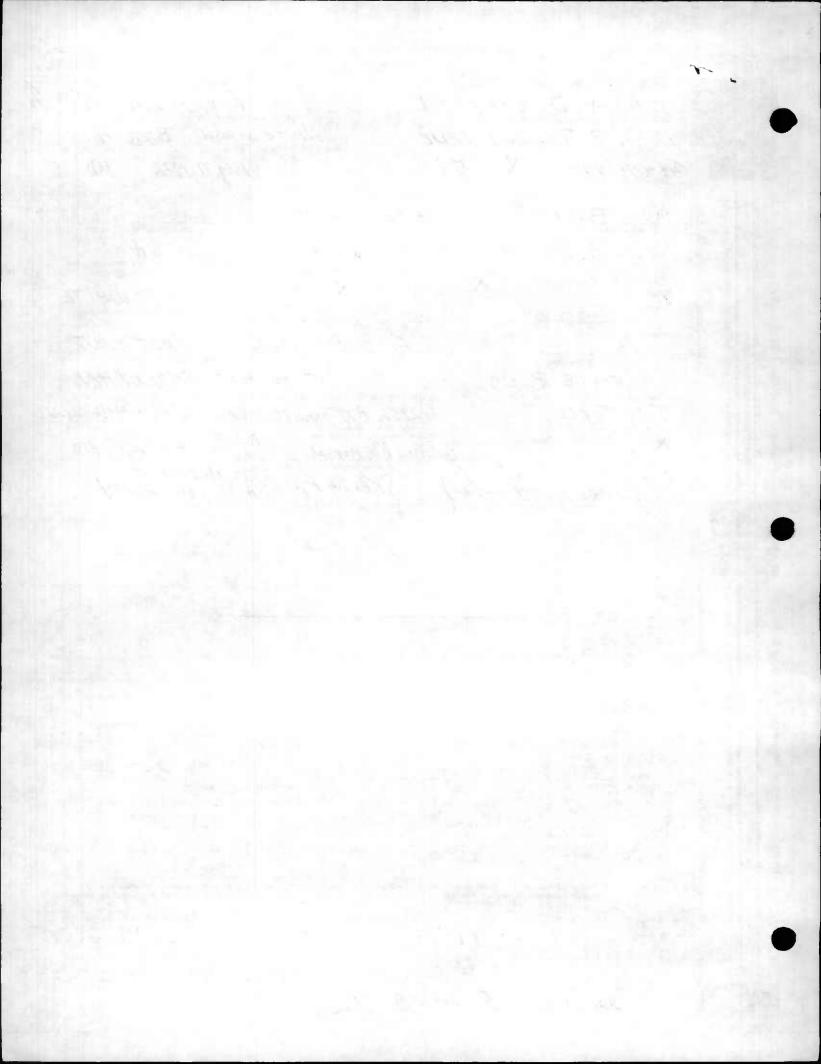
32. Registrar's Signatura

9105

29c. License number

29d. Date signed (Month, Day, Year)

Square Drive, Baltimore MD 21237



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month 28,2000 11:35pm May 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) Months Hours 10 M 2 F 1C Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Insida City Limits Baltimore 1 Yes 2 No apkvill 10f. Zin Code 10g. Citizen of What Country? 10a. Street and Number 21234 154 12. Was Decedent Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexicen, Puarto Rican, etc.) Race - Amarican Indian Bleck, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2MNo Specify Specity: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) manufacturing com Elementary/Secondary (0-12) College (1-4or 5+) 191100R 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Malden Sumeme) anet 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Blvd #2313 20b. Place of Disposition (Name of cemetery, cremetory or other place) Baltimore. VIRGINIA (20a. Method of Disposition 20c. Location - City or Town, Stata Date 31 May 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Funeral Farvice Licensee 8800 Hartor 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disaese or condition resulting in deeth) Due to (or es a consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco was contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes en autopsy performed? 24b. Ware autopsy findings available prior to Aoster Abdominos Procurya completion of causa of death? Roser 1 Yes 2 No t □ Yas 2□ No 25. Was case refarred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Cartifier (Check only one)

permit. Pages 1 and 2 ahould be filed within 72 hours after dea.
Department of Heelth and Mental Hygiene.
Important: If Item 27 Is marked other than "nature"
any injury or other traumatic acceptant. Physician /Medical Examiner The law requires that the death certificate be executed Division of Vitai Records, P.O. Box 68760, or Attending Physician: Aftert after deeth.

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of in by the fu within 24 hours a To the Funeral L completely

Physician

Examiner

Funeral

Director

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Certification:

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DHMH 16 Rev 6/95

State Registrar

Bay 31. Date tiled (Month, Dey, Year) JUN 0 1

29b. Signeture and title of certifier

01

Godsoff MD

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

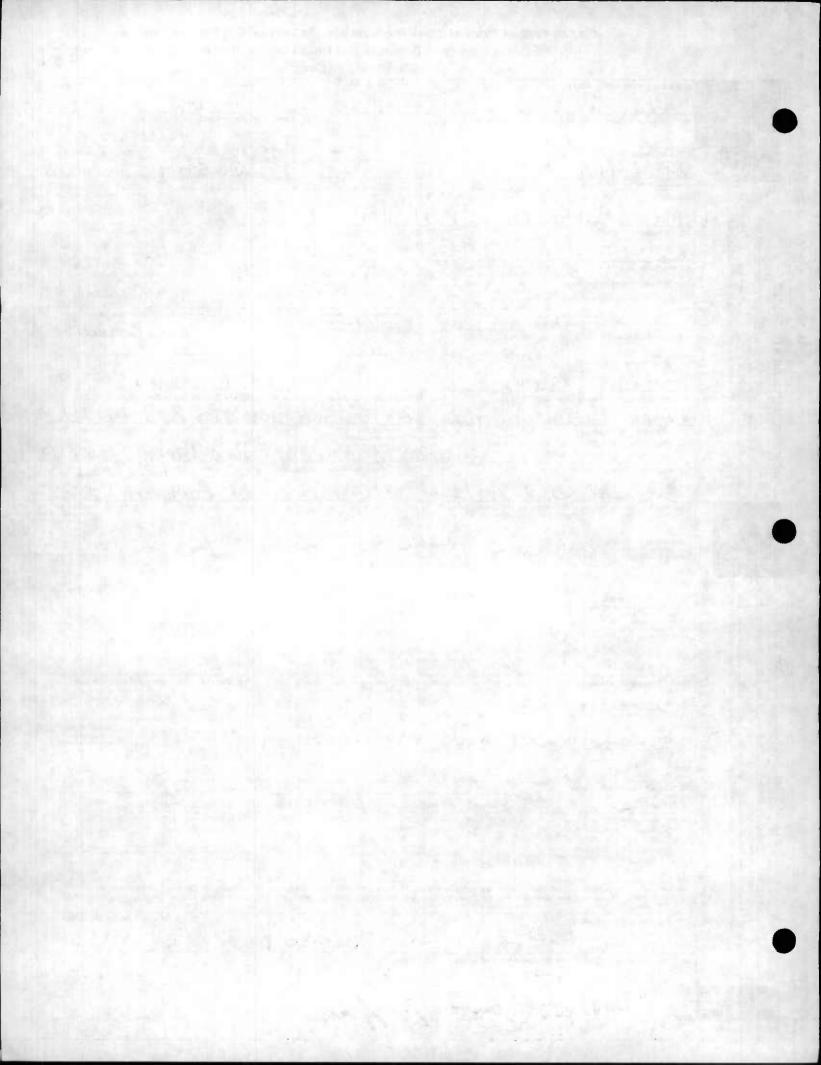
29c. License numbe

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ORIGINAL

29d. Date signed (Month, Dey, Year)



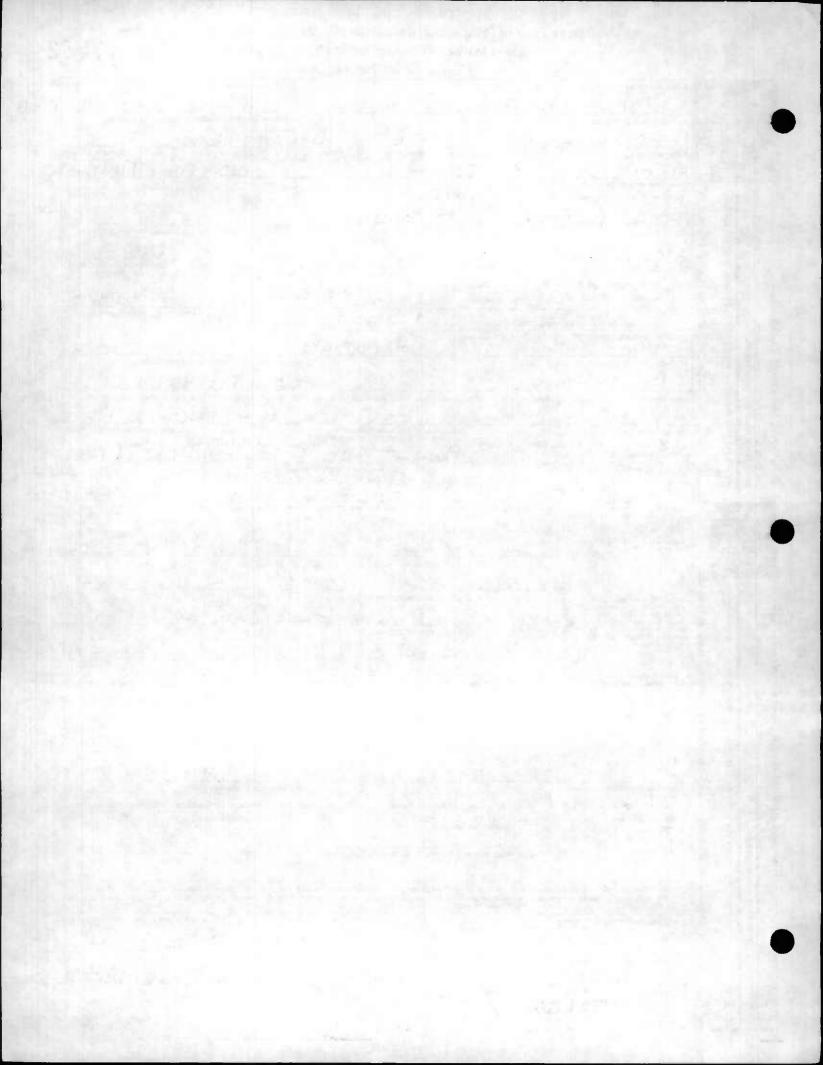
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** ath | 4c. County of Death HARMER ARIS 10:29A.M IAY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner 5. Social Security Number 6. Sex HOSPITAL

7. Aga (In yrs. last birthday) BALTI mores If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign **Funeral** Days Months MARY 10 M 250 F Director 21201875 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a State 10c City Town or Location r than "natural", or itema 23a or 28a-f ahow the Medical Exemples must be notified at 1 Yes 2 No Director BALTIMORE MARYLAM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code KOAC 21937 RAI 2703 Funeral filed within 72 hours after deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White, etc. 1 Yes 250 If Yes, Give Year or Detes: 1 Never Married 20 Married 280 No 21215-0020 1 ☐ Yes 20 No Specify: Specify: p WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER Hors 9YRS Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) Be Pages 1 and 2 should be sent of Heaith end Mental HARRER ANGEL GIARY Binnis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 PARKVILLE If Item 27 is 3-W 400 EMERAL MARYLAND (2000) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MAY 30 20a. Method of Disposition Burial 2 Cremation 3 Removal from State EARROLL TO. 1ARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) YALLAY 2000 22. Name and Address of Facility 21. Signatura of Funerel Servica Lich 21234 EMORIES 8800 HARFORD ROSO 1ARYLADO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause or each line. Approximate Interval Batween Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in daath) /Medical 30 min Examiner Due to (or as a consequence of) ocendral Examine HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) and attending physician rerosc/enotic Physician/Medical the 1 Due to (or as e consequence of) 80 per tousius 080 Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Aq of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page Yes Yes 2 | No 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA edical Certification: To After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending 5 Pending investigation Natural Injury after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 | Homicide To the Hospital
within 24 hours a
To the Funeral C 29a Certifier 76 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifia 29c. License number 0039297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSPA ROSO LARREY MARYLAND 2314 2957 130 HAZ 32. Registrer's Signature 31. Date filed (Month, Day, Year) State JUN 01

Registrar



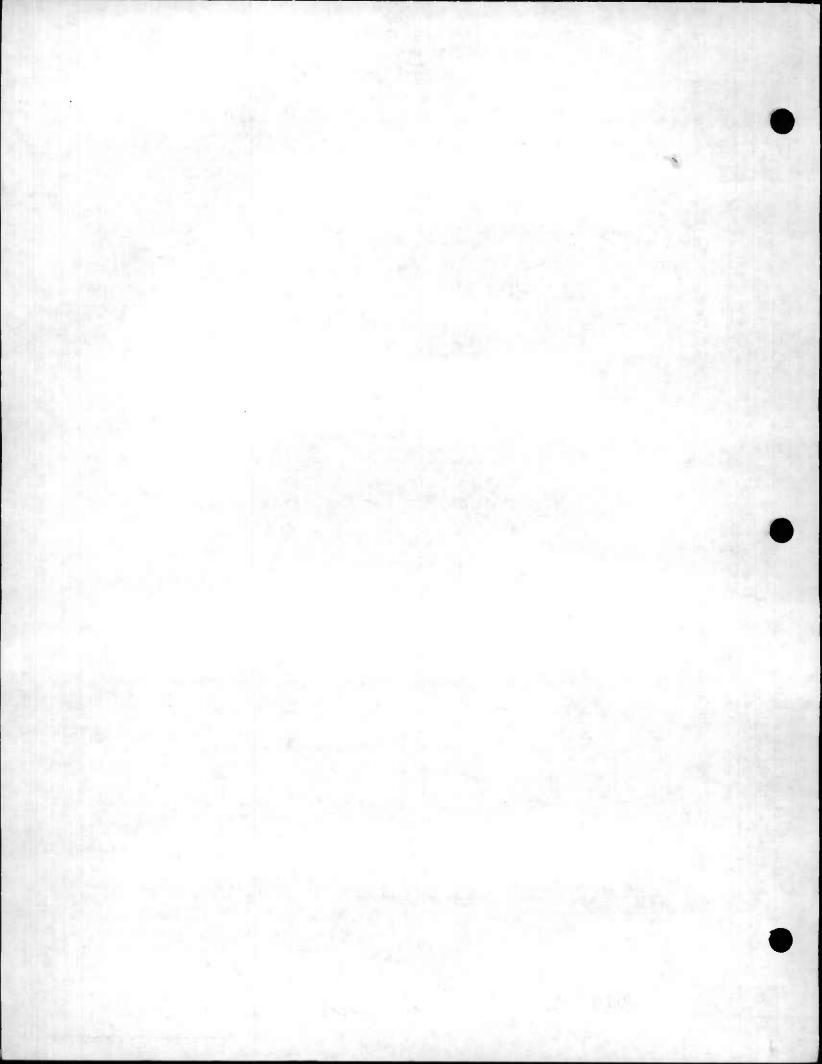
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State of Maryland / Department of Health and Mental Hygiene 17 463

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4 □ Donetion 5 □ Other	n 3 Removel from State (Specify)	0	RN STAF			MAY 27	BALTIMO	RE, MD.	
21. Signature of Funaral Service	e Licensee	0				NUTTER FU			c.
Franct +	1411	le	2501	GWYNN		PKWY BAI			
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DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible., State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month Yeer 3:18 PM ALBERT VINCENT EVANS MAY 31 2000 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth SAMARITAN HOSPITAL BALTIMORE If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Deys Months 1 MM 2□ F 214-12-969 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 V.S.A CARTER 6101 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 2 Married 1□ Yes 25 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) INDEPENDANT! Elementery/Secondery (0-12) College (1-4or 5+) SELFEMPLOYED T.V. REPair/ELECTRONICS 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) ALBERT A. MARY JANE STEVENS 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) CARTER AVE BALTIMORE, MD 21214 CATHERINE EVANS 6101 SPOUSE 20b. Piece of Disposition (Name of cemetery, cremetery or other plece) JUNE 3 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State PARKVILLE, MD PARK WOOD CEMETERY 2000 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility EVANS Funeral Chapel tinney RD. Parkville, MD. 21234 8800 Harford 23a. Pert1. Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) Months Year 5 Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Examiner Box 68760 P.O. Division of Vital Records, The law requires To the Hospital or Attending Pr within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funera

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked other any Injury or other treumatic event page.

Physician /Medical

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After this certificata

filed within 72 hours after death

Baltimore, Maryland 21215-0020

Physician/Medical Examiner by Completed Be 25. Wes case referred to medical 1 Yes 2 No edical Certification: To 27. Menner of Death 1 Neturel 2 Accident 3 Suicide 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) end manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29e, Certifier 29d. Dete signed (Month, Dev. Year) 29b. Signeture and title of certifier 29c. License number June 1,2000 and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 5601 Loch Raven Seide BLVD. Baltimore

State Registrar

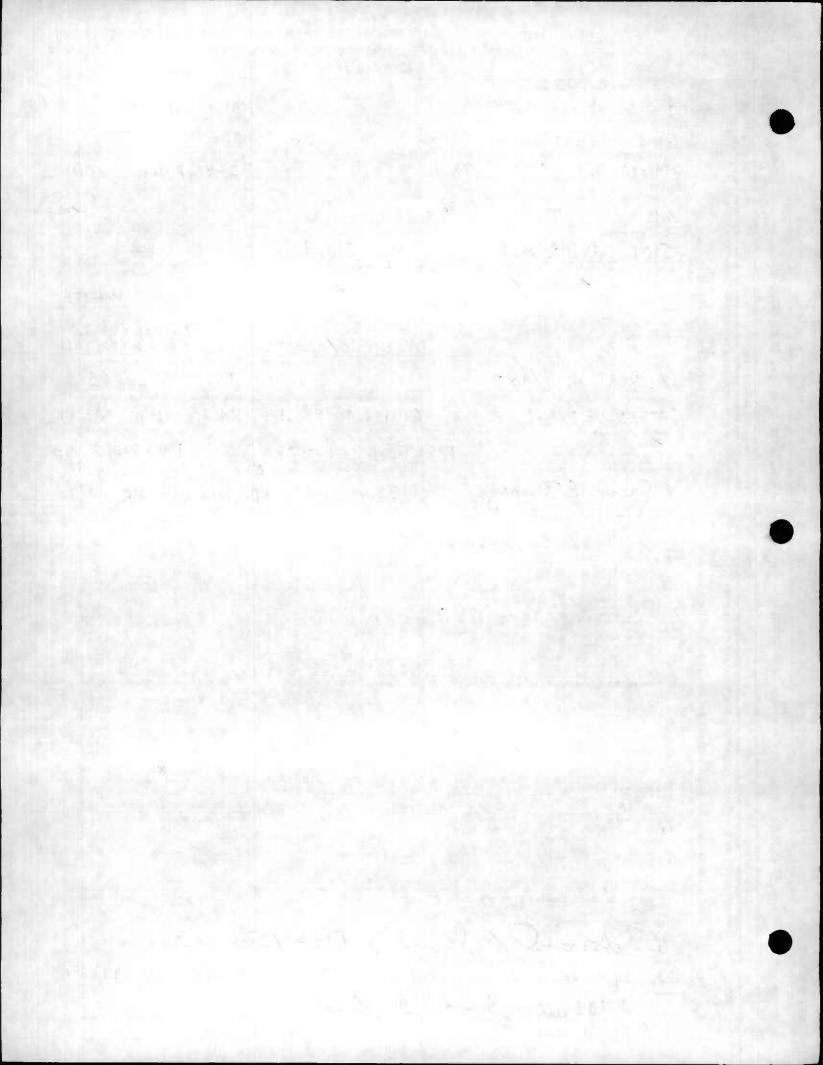
DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year) JUN 0 1 2000

EdwardA

32. Registrer's Signeture

MD



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #5 PER F.H. G784 6-15-00 WR. Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death May 24, **Physician** David Calvert Evers 2000 4:50 P.11. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not institution, give street and number) **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 021 - 24 - 6585 8. Dete of Birth (Month, Dey, Year)
March 14, 1932
New York 7. Age (In yrs, last birthdey) **Funeral** Months Deys Hours 10 M 20 F 68 Yrs. Director Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Crownsville Maryland Anne Arundel Norris 23a or 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1304 Tall Timbers 21032 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 72 hours after 1 Never Merried 2 Married ò White 21215-0020 1 Yes 2 No Specify Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ould be filed within Mental Hygiene. Elementary/Secondery (0-12) al Hygiene. College (1-4or 5+) Regional Sales Manager Manufacturing Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Richard H. Evers Harriett C. Low of Health and Menta Items 27 is marked Pages 1 and 2 should 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Brenda E. Palo (Spouse) 1304 Tall Timbers, Crownsville, MD 21032 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of It Important: If its any injury or of once. 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Metro Crematory, Inc. 5/30/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility of Funeral S Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD 21122 title that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, cause on each line. 23a. Pert1. Enter the disease, or co shock, or heart failure. List on Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Physician/Medical Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to 0 Box 68760. the Due to (or as a consequence of) signed by the ettending p Part !!. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part !. 23b. Did tobacco use contribute to the cause of death? P.0. 3 Probably 4 Unknown 1 Yee 2 No of Vital Records, Completed by 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28h Time of 28c. Injury at Work? After t Division 1 Naturai or Attending 5 Pending investigation 1 Yes 2 No within 24 hours effer death. To the Funeral Director: A completely filled in by the fu 2 Accident 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Pleca ol Injury - At home, larm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. 29a. Certifier (Check only To the h 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 46303 deeth (Item 23e) (Type, Print) 30. Name end address of person who complete

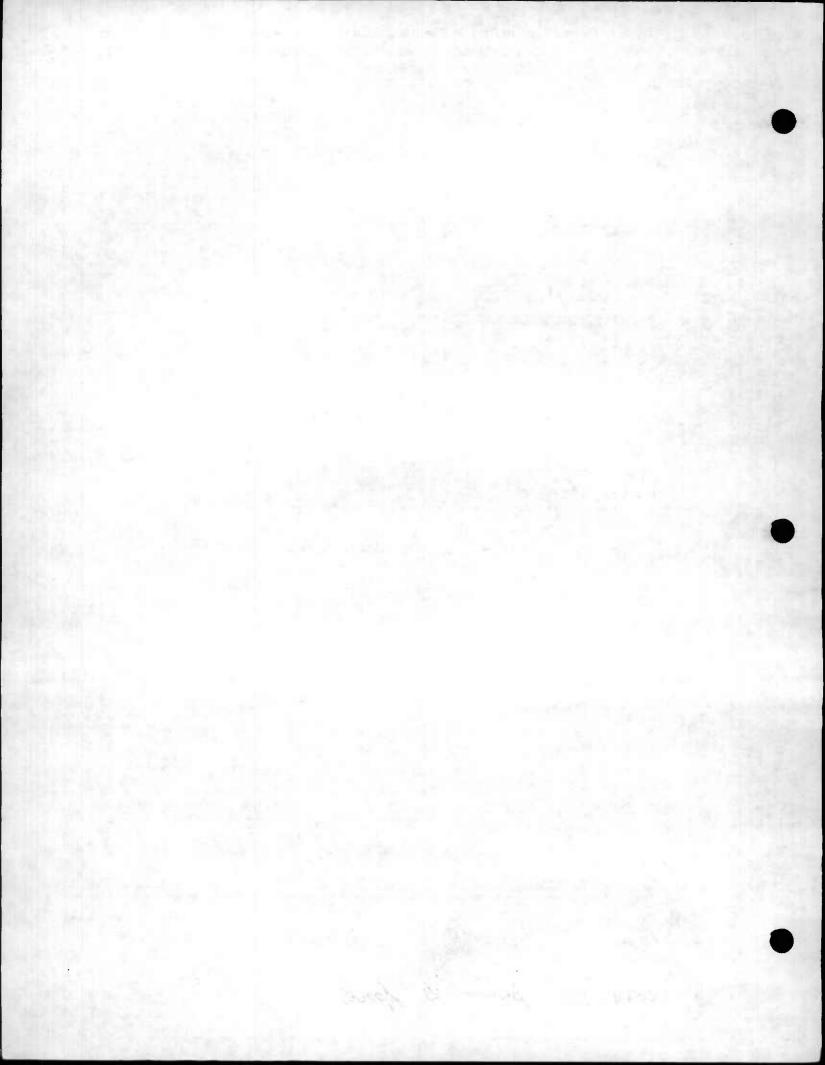
Registrar

State

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22. Registrar's Signaty

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEMS #17,#18 PER FH G78 4 6/1/2000 AH Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth May 6:45 P.M **Physician** Edwards Beatrice 30 2000 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give streat end number) 4c. County of Death Examiner Arundel Hospital Glen Burnie Anne Arunder North If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) 5. Social Security Number **Funeral** 1 M 2 F 5 220-12-4679 **Director** Mary Jand Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23e or 28a-f sho other traumatic event, the Medical Examiner must be notined at 1 Yes 2 No Severn Directo Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21144 809 meade Villiage Circle Funeral 12. Was Decadent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Status is 1 and 2 should be filed within 72 hours after in Heelth and Mental Hygiene. Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Black altimore, Maryland 21215-0020 Specify: ģ 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Admin. Ass 17. Father's Name (First, Middle, Last) IAWRENCE MARTIN 18. Mother's Name (First, Middla, Maidan Sumama) EATRICE Be BERTHA GREY Lo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Edwards Villiage Circle, Seven, MD 21144 1809 Meade Lynne /Daughter 20b. Pleca of Disposition (Name of camatary, crametory or other plece) 20a, Method of Disposition Department of F important: if its any injury or of 1 Deurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion emeterry 21. Signature of Fuheral Service Licen-22. Name and Address of Facility Close Hari 10515 709 Tessier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical a ATMEROSCUE ROTTE **Examiner** Physician/Medical Examiner (DBON BOM ARTERY りなもろう The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last ettending physician end for use es the burial-tran Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760, HUPERTENSION Due to (or as a consequence of) 23b. Did tobacco use gontribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detec à 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy Completed 1 □ Yes 2. No 1 □ Yes 2 □ No certificate or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mannel of Deeth Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. tnjury at Work? Certification: After Natural 5 Pending investigation s after deeth. 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier Medical (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

2000

To the Within 2 To the

State Registrar

29b. Signeture and title of certifier

Aloka Oresum.

31. Date filed (Month, Day, Year)

JUN 01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

) Hozpial 32. Registrar Signat

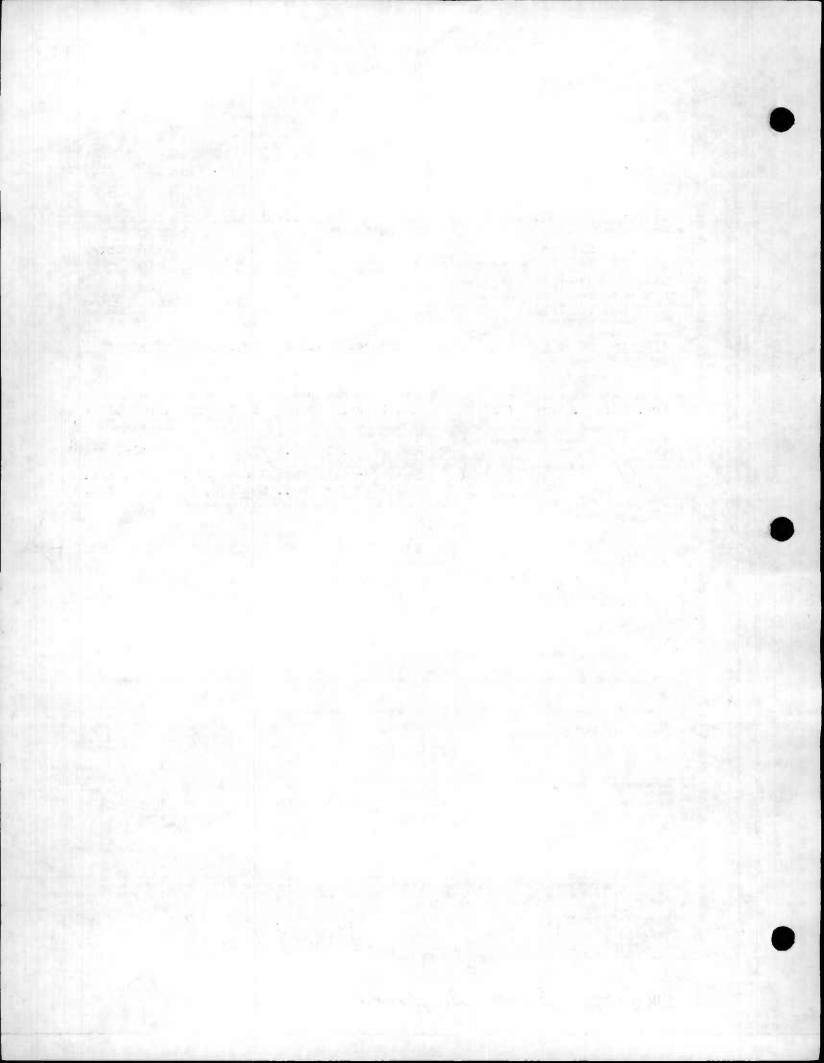
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State of Maryland / Department of Health and Mental Hygiene 00 17467

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	la Facility Name (If not institution, gi	va street and number	7)			48	City, To	wn, or Lo	cation of Dea		nty of Death	
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	5. Social Security Number 6.	Sex 7. A	ge (In yrs. last		If Under 1 Months	-	If Under Hours		8. Data of B	irth	-	placa (State or Fore
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L	5 Years			Tr	actor						eight	
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L	Henry Isaac For	rd ————					Am	anda	Donov	an		
1	19a. Informant's Name/Ralationship									ber, City or Tox		
L	Mrs. Lois N. Fo	ord (Wife					Lane	Mı		iver, M		220
2	20a. Method of Disposition 1	Removal from State	00000	of Dispos tary, crem	ition (Name atory or oth	of er place)	i	Date	20c. Locatio	n - City or T	own, State
	4 □ Donation 5 □ Other (Speci			lens	of Fa:	ith	Cem.	6/3	/2000	Rosed	ale,	Maryland
3	21. Signature of Fyneral Service Lice	nsee	0	22.	Name and	Address	s of Facilit	y 1	Homo o	f Dunda	11. T	200
	Many S	26	X							Maryla		1222
+	23a. Part1. Entar the disease, or con shock, or heart failure. List only	nplications that cause	ed the death. D	o not enta	r the mode	of dying	, such as	cardiac o	r respiratory	arrest,	IId Z.	Approximata Intarval Between
	shock, or heart failure. List only	one cause on each	line.									Intarval Between Onset and Deat
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A Medical Examiner	resulting in death) Last		200 10 (01 03	a consequ	onos ory.							
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2		1 Li Inpat		Outpatient	3□ DOA		C 4□ Nu	rsing Ho	me 5□Res	sidence 6 🗆 0		ify)
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Day **Physician** MA 27.200 Hugh Ellis Faucette, Sr. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner H Under 1 Year | H Under 24 Hrs. | 8. Date | Months | Days | Hours | 4. | AACOUNTY HOSPITAL 5. Social Security Number ARUNDEL 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□ F 244-26-7150 Yrs. May 9, Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a U.S.A. 102 Ferndale Avenue 21061 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1945b 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 Divorced 1951 Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Stationary Engineer Refinery filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Mental Pages 1 and 2 should be 2 Thomas Faucette Mattie Bud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Separtment of Health an important: If them 27 is 102 Ferndale Avenue, Glen Burnie, Maryland 21061 Effie Faucette- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removat from State 6/1/00 Brooklyn Park, MD Cedar Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, PA. 21. Signature of Funeral Service Licenses 1401234 1 Second Avenue, S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or compligations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

1. Decedent's Name (First, Middle, Last)

Physician /Medical Examiner The law requires that the death certificate be executed

Box 68760,

P.O. 1

Records,

Division of Vital

Hospital or Attanding Physician: 24 hours after death.
 Funeral Director: After this certifica.

To the Vithin 2

Immediate Cause (Finat disease or condition resulting in death) Physician/Medical Examiner Be Completed Certification: To 2 filled in I

Medicai

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy 1 ☐ Yes 2 No 1 □Yes 2 □ No 25. Was case reterred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how Injury occurred 1 Neturat 5 Pending Investigetion 1 TYes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Certifier (Check only one)

29c. License number

lentricolar Febrillation

Due to (or as a consequence of):

Keart Sieau

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Dete of Death

Month

7468

3. Time of Death

Birthplace (State or Foreign Country)

North Carolina

Black, White, etc.

Claiborne

29d. Date signed (Month, Dey, Year)

or Ste215 Glen Burnic mp2 1061

White

Approximete Intervet Between Onset and Deeth

10d. Inside City Limits 1 ☐ Yes 2X No

3:00Pm

Registrar

completely

31. Date fited (Month, Day, Year) 2000

29b. Signeture and title of certifier

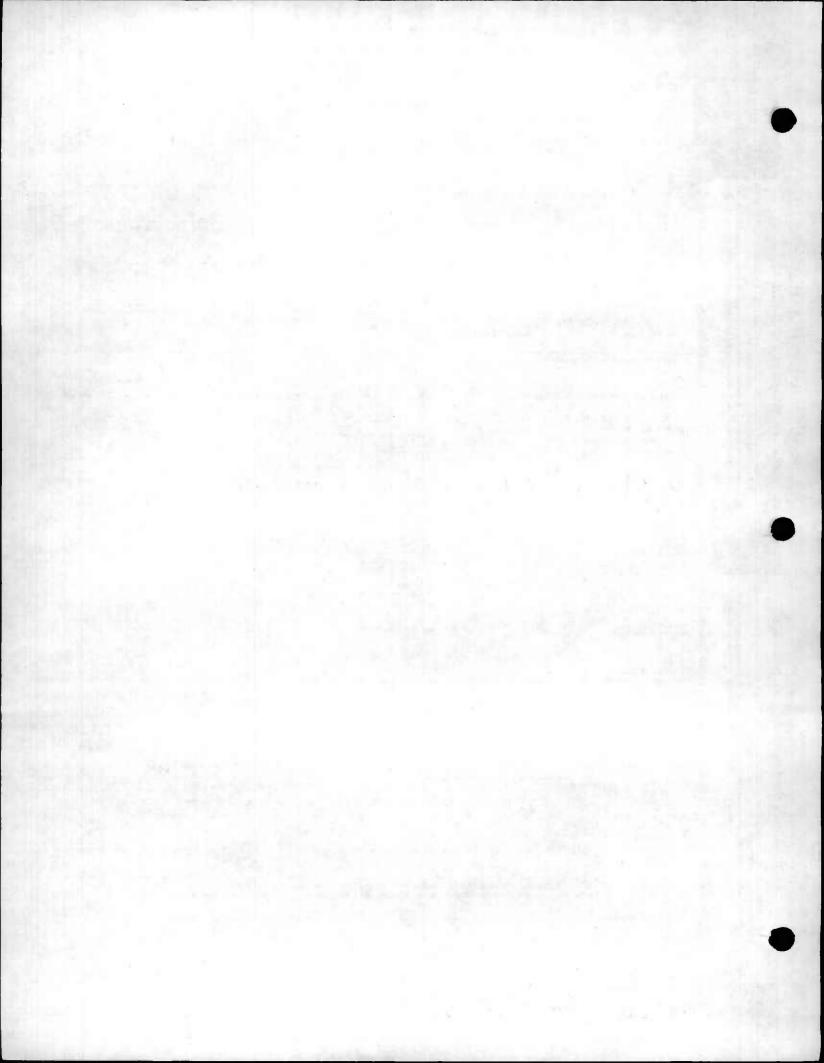
AVID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature winks

DHMH 16 Rev 6/95

300 HOSPItal



GREGORY FISHER State of Maryland / Department of Health and Mental Hygiene

7.0	20-41	Decedent's Name (First, Middle, Last) GREGORY PATRICK FISHER										Year	3. Tima of Death	
nysician Medical	GREGORY	PATRICK	FISHER							Month MAY	24 2	2000	21:29	
kaminer	4a Facility Name (If	not institution, gi	e street and nur	n <i>ber)</i>				4b. City, To	wn, or L	ocation of Deeth	on of Deeth 4c. County of Deeth			
	1838 RAN	ASEY ST	REET					BAL	TIM	ORE	N/A	A		
neral ector	5. Social Security No. 213-92-04		Sex 10XM 2□ F	7. Age (In yrs. las	t birthdey) Yrs.	If Under Months	1 Yeer Days		24 Hrs. Min.	(Month, Day		Cour	• •	
Ctor	Usual Residence of			30			-			AUG 22,	1909	MAR	YLAND	
Examiner must be notified at by Funeral Director	10a. State	10b. County		10c. City,	Town or Lo	cation			V.			1	10d. tnside City Limit	
ŏ	MARYLAND	N/A		BALT	IMORE	2							1 ∑ Yes 2 □ No	
Directo	10e. Street and Num	nber				10f. Zip	Code		-	1	l0g. Citizen of	What Cour	ntry?	
			1117										,	
20	1913 WILK	ENS AVER		2122:					1.0.10			S.A.	an Indian	
Funeral	11. Maritel Stetus		Armed Fo	12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Deceder If Yes, specify					gin? (Sp , Puerto	o Rican, etc.)	14. Ha	ce - Americack, White,		
F	1 Never Marrie		1 Yes If Yes, Giv	9	1□ Yes 2	2 ₩ No	Specify:			Speci	HITE			
d by	3 Widowed	4 Divorced	Year or D	-								, WI		
Completed	(Speci	15. Decedent's E	ducation ade completed)		6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)					king	16b. Kind of E	Business/In	dustry	
duo	Elementary/Secon		College (1	-4or 5+)			e retire	ed)			77377	NOWN		
Ö	12			0	UNK	NOWN					Leave Filter			
merked other ametic event To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme)											me)		
	RICHARD	DENNIS I	FISHER					GERA	LDI	NE SHARO	N FITZE	PATRIC	CK	
	19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)											Code)		
	GERALDINE SHARON FISHER / MOTHER 1913 WILKENS AVENUE, BALTIMORE, MARYLAND											21223		
and a	20a Method of Disposition 20b, Place of Disposition (Neme of Date 20c, Location - City or T													
nu's or	1 Buriat 2 M Cremation 3 Removal from State 4 Removal from State 4 Removal from State 4 Removal from State 5 Other (Specify) METRO CREMATORY, INC. 5/30/2000 BALTIMOR										MORE,	MARYLAND		
any injury or	21. Signature of Funeral Service Licenses 22. Name end Address of Fecility													
and and	HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE, BALTIMORE, M												77 AND 0100	
	23a Pari 1 Enter th	a disassa or com	nlications that o	suced the death	Do not ent							MARY	YLAND 2122 Approximete	
	23a. Part 1. Enter the shock, or hear	t failure. List only	one cause on e	ach line.	20 1.01 0111		_ 0. uy		-0.0100	or rouphatory an	-54,		Interval Between Onset and Death	
ian cal	Immediate Cause (F	Einai		MARCO	TTC T	NTTONE	CAM	TON				1		
er	disease or condition resulting in death)	1	a	NARCO	IIC I	NIOXI	CAT	ION				1		
	resultary in death)			Due to (or e	s a consec	uence of):	-			They be				
ine	100													
edicai Examiner	Sequentially list con	ditions,	D. —	Due to (or a	s a consec	uence of):								
M	Sequentially list con if any, teading to im- ceuse. Enter Under	mediete tying												
cai	Cause (Disease or I that initiated events resulting in death) L	DILIEV	C	Due to (or a	s a consen	uence of):								
8	resulting in death) L	ast		220 10 (01 4										
cian/Med			d											
be detached for use as the but by Physician/Medical										l est mi				
ysi Vsi	Part II. Other signific	cant conditions	contributing to de	eath but not resulti	ng in the u	nderlying c	ause gi	iven in Part I					o the causs of death	
d be detached for	100									104	'es 200 No	3 Probably 4 Unknow		
	71295							400			41 71	24b 14	fere autopsy findings	
Page 78										24a. Was a	an autopsy	240. W	ailable prior to	

To the Hospital or Attending Physician: The law rewithin 24 hours after deeth.

To the Funeral Director: After this certificate has bee completely filled in by the funeral director, page 2 sho **Division of Vital Recc** Complet Be Medicai Certification: To

completion of ceuse of death? 10 Yes 2 No 1 Yes 2□ No

25. Was cese referred to medicel							26
examiner? 1 X Yes 2 ☐ No	Hosp	oital: 1 🗆 inpatient	2[ER/Outpetient	3 🗆	DOA	Other:
27. Manner of Death 1 □ Naturat 5 □ Pending 2 □ Accident investigetic	2	28a. Date of Injury (Month, Dey Ye FOUND:		28b. Time of tnjury FOUND:			tnjury at Work? 1 🗆 Yes

etient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 Suicide 4 Homicide

SUBJECT INGESTED DRUGS 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1838 RAMSEY STREET BALTIMORE, MARYLAND

MAY 25, 2000

FOUND AT RESIDENCE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature end title of certili

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

111 Penn Street, Baltimore, Maryland 21201

26. Piace of Death (Check only one)

2 No

O.C.M.E.

State Registrar

27

31. Date filed (Month, Dey, Year) JUN 0 1 2000

33N 01 2808 Jane 1 / Law

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 1771 10. a 16 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deal 4c. County of Deeth Examiner MORR If Under Months 7. Age (In yis, last birthday) 5. Sociel Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 10 M 25 F 115-24-901 Director ali Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified as 1 ☐ Yes 2 No **Funeral Director** 10f Zip Code 10g. Citizen of What Country? 10a Street and Number Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specity: While by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filted wit Department of Health end Mental Hygiene Important: if Item 27 is marked other truamptic event, and price. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide Be SMONICC 20 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 19a. Northwind May 30 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) omo 21. Signature of Fureiral Service Lice vans 22. Name and Address of Facility 8800 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final · O SHYDRAT DOTO disease or condition resulting in death) 101 Ex_miner Due to (or as a consequence of): Physician/Medical Examiner OAT TZY physicien end the burial-transit The law requires that the death certificate be axecuted Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury LIA RKAL 35 ZYAO E Box 68760. that initiated events resulting in deeth) Last Due to (or as a consequence of): 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 42 Unknown 1 Yss 2 No of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 25 No 15 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this To the Hospital or Attanding P? within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1'SANatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and mannar es steled.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of per who completed cause of death (Item 23a) (Type, Print) 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

F.

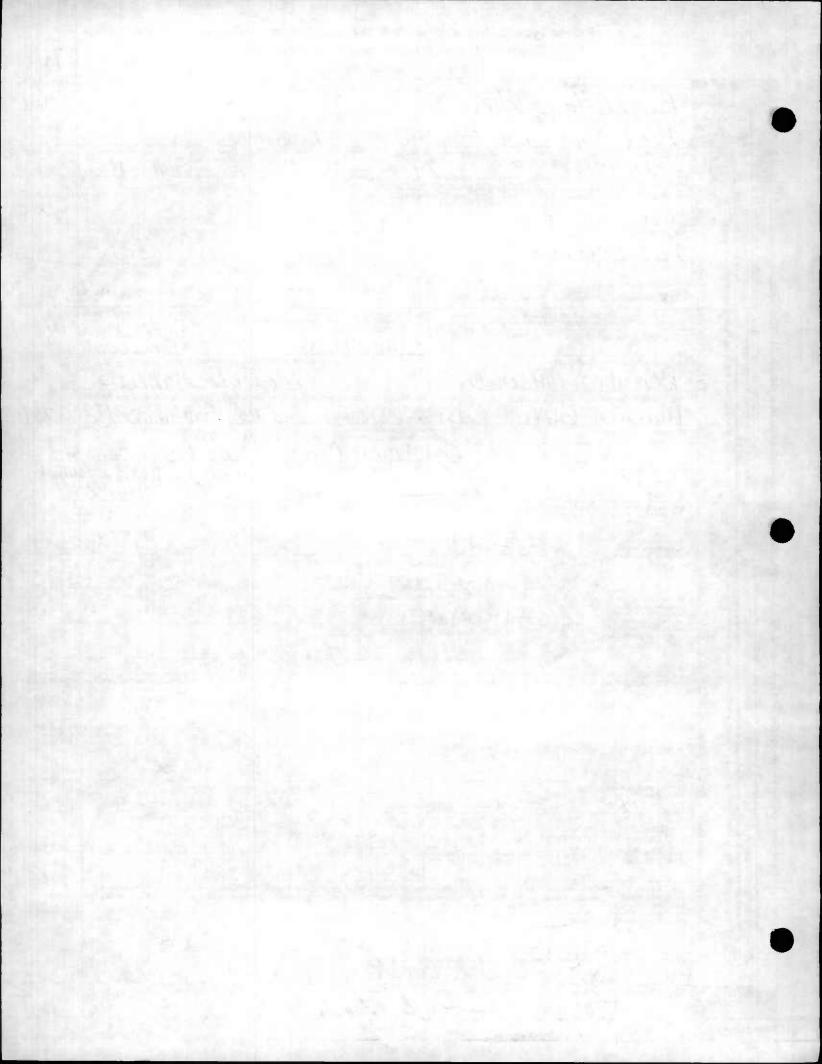
Registrar

JUN 0 1 2000

Seneral Signature

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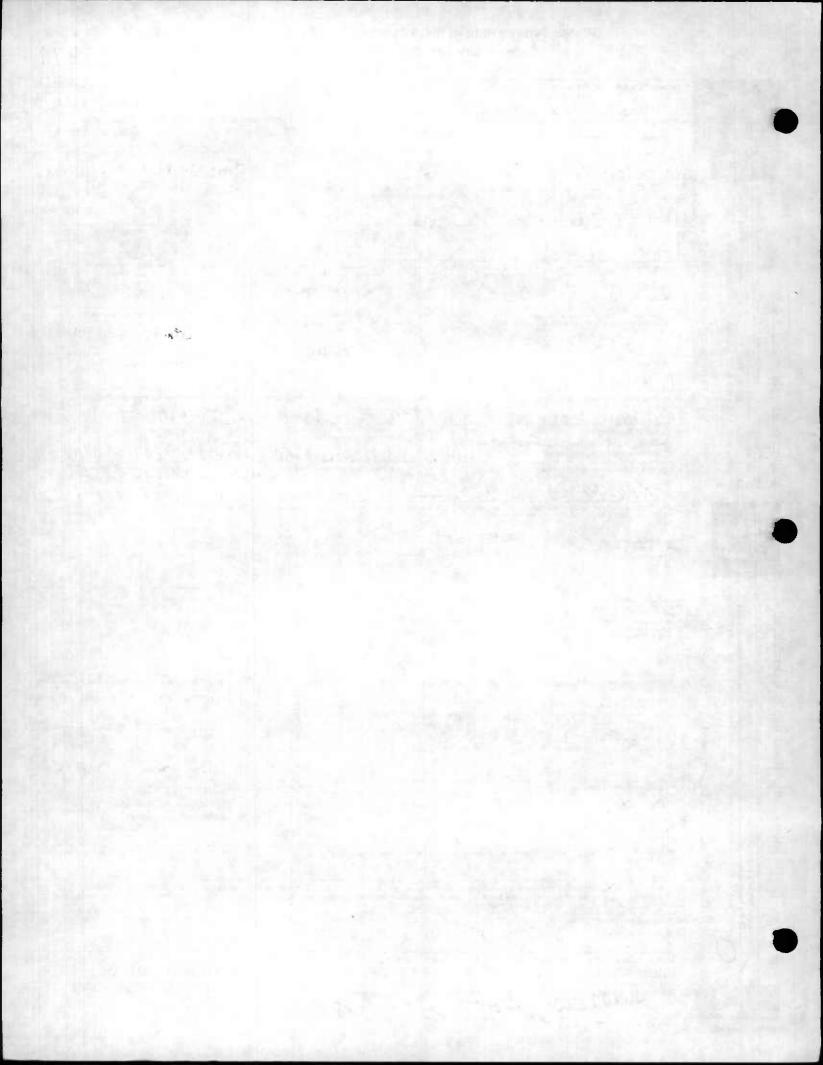
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Day **Physician** George MAY 2000 3:20 AM adine /Medical 4a Facility Name (If not Institution, give street and aumber) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 F 220-22-1431 Usual Residence of Decedent 24 1927 Director June Mari with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 2 No altimor Directo OWSON 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 Funeral filed within 72 hours after deeth Rema 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Marriad 2 Married 8 Specity: White Baltimore, Maryland 21215-0020 1 Yas 2 No Specify à 3 Widowed 4 □ Divorced "neture!" Completed 15. Decedent's Education (Specify only highest grade completed) 16s. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry taste of Maryland al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HCHNICIAN permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important; if Itam 27 is marked other any Injury or other traumeth 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middla, Last) 8 Illiam helma P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) altemore Md 21234 Illiam SON 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date Sure 3 1) Burial 2 Cremation 3 Removal from State 2000 4 ☐ Donation 5 ☐ Other (Specify) Evans 21. Signature of Euharal Service License 22. Nama and Address of Facility 8800 Harlord 21234 Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** UROSEPSIS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner The lew requires that the death certificate be executed burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last pue Dua to (or as a consequence of): physician Box 68760 Physician/Medical the Due to (or as a consequence of) 980 Po Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 20 No 3 Probably 4 Unknown PNEUMONIA of Vital Records, by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed CIRRHOSIS 2 05 No 1 Yes 20 No certificate 1 Yes or Attending Physician; 25. Was case referred to medical examiner? edical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No s after death.

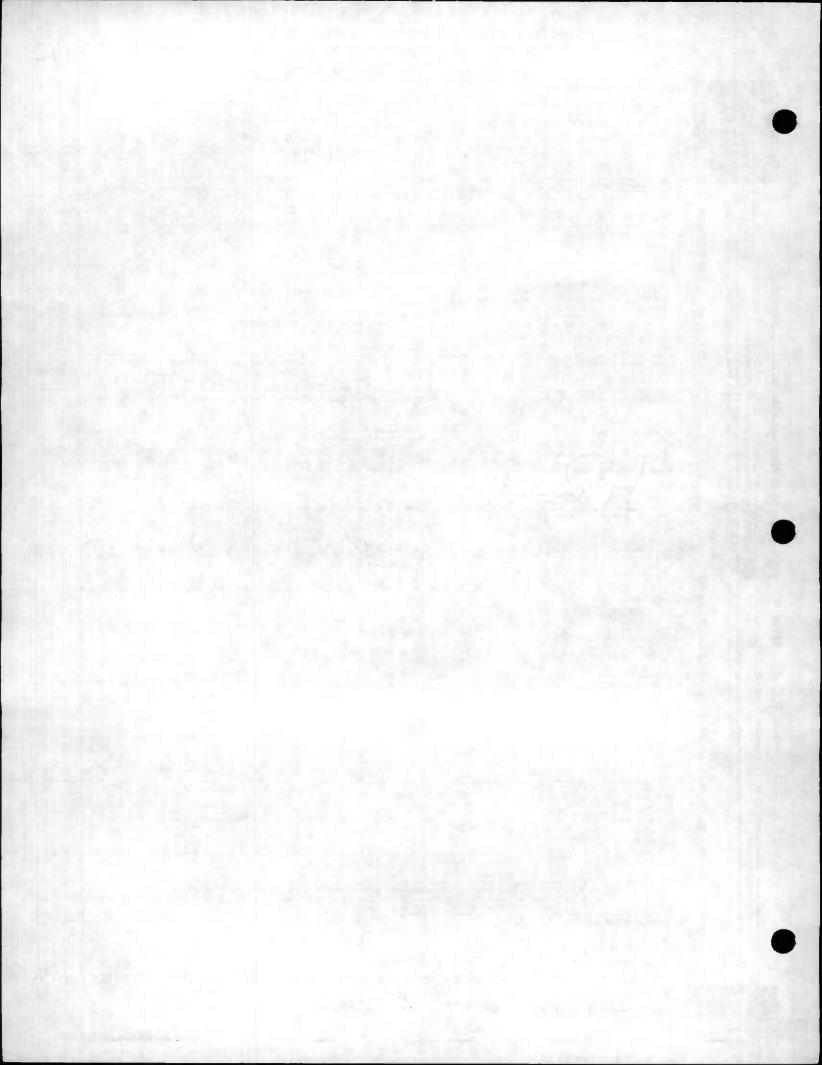
If Director: After this ed in by the funeral d this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurei Route Number, City or Town, State) 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homlcide To the Hospital of within 24 hours of To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D 37254 6-1-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 BOON P. LIM, M.D., 31. Date filed Many, Day, Year) 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene 00 17472

			C	ertificate d	of Death	1	Re	g. No.			
	1. Decedent's Name (First, Middle, L.	est)	THE STATE OF				ate of Death	Day	Year	3. Time of Death	
Physician /Medical	WALTRAUD K. GIDD:	INGS		Y 30,	2000	1981	5:00 P.M				
Examiner	4a Facility Name (If not institution, gi	ve street and number,)		4b. City, T	own, or Locatio	n of Death	4c. County	of Death		
	302 MARIE AVE.		BURNIE		ANNE A		EL				
Funeral Director		Sex 7. A	ear If Unde	Min. MA	ate of Birth Month, Day, RC. 5	Year) 1928	9. Birthplace (State or Foreign Country) GERMANY				
2	Usual Residence of Decedent		T								
Marylar a-f show ured	MARYLAND ANNE ARI	JNDEL	GLEN BUI				10d. Inside City I				
72 hours elter death with the Maryland natural; or thems 23a or 28a-f show direl Examiner must be notified at etd by Funeral Director	10e. Street and Number 302 MARIE AVE.			10f. Zip Coo 21(10g. Citizen of What Country? UNITED STATES				
fler death v	11. Marital Status	12. Was Decedent Armed Forces	Ever in U,S. 1	3. Was Decedent It Yes, specity (of Hispanic O	rigin? (Specify	Yes or No-		e - Americ	en Indian,	
ours after al., or hu by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Dates:		1 ☐ Yes 2X			, 0.0.7		WHIT		
"netural", alice E	15. Decedent's E (Specify only highest gi	ducation	16a. De	st of working	1	6b. Kind of B	usiness/In	dustry			
ified within 72 hours of Hygler than "natural", or out, the Medical Exercises Completed by F	Elementary/Secondary (0-12)	College (1-4or	5+) life	S CLERK	tired)	st or working		RETAI	L SAL	ES	
the file	17. Father's Name (First, Middle, Las (UNKNOWN)	WALTERS			18. Moth	ner's Na <i>me (Fir</i> LRA		laiden Suman UNKNOWN			
e, Mal ylo	19a. Informant's Name/Relationship RICKY GIDDINGS /		910	LANGLEY	RD., G						
Pa Pa Pa	20a. Nethod of Disposition 1 Burial 2 Cremation 3 S 4 Dogation 5 Other (Speci	JRNIE, MARYLAND									
pemit. Pa Departmer Important eny Injury	21. Signature of Funding Service Lice	nsee	ŀ	22 Name and A IRKLEY-1 21 CRAIN	RUDDICK HWY.,	FUNERA S.E.,	L HOMI	E, P.A. BURNIE	, MD	21061	
	23a. Part1. Enter the disease, or cor shock, or heart tailure. List ont	nplications that cause	d the death. Do not	enter the mode of	dying, such a	s cardiac or res	piratory arre	st,		Approximate Interval Between	
asth certificate be assected attending physician and for use as the burist-transit claryMedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a cons	S LMO K a sequence of):							
death certification at for use a sician/M	Part II Other classificant conditions	d.	and and an analytic to the		ahaa ia Dad		22h Did toh		etelbute t	the series of deet	
bat the datach	Hyperteusion		out not resulting in the		23b. Did tobacco use contribute to the 1 ☐ Yes 2 ☐ No 3 ☐ Probably						
aw requires been 2 should							24a. Was an perform	autopsy ned?	87	ere autopsy findings allable prior to impletion of cause death?	
							1 ☐ Ye	s 2 No	11	Yes 2 No	
yelclen: The is s certificate ha director, page	25. Was case reterred to medical examiner?				26. Pla	ce of Death (Ch	eck only one	a)			
	1 ☐ Yes 2 ☒ No	Hospital: 1 Inpati	ent 2 ER/Outpa	ient 3 DOA	Other: 4 D	lursing Home	5 Neside	nce 8 Oth	ner (Speci	(y)	
After fune	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury	ury 28b. Time ay Year) Injur		Injury at Work? 1 🗌 Yes 2 🛭		Describe ho	w injury occur	rred		
bal or Attending P is after death. al Director: After ted in by the funeration: Certification:	3 Suicide 6 Could not determined	200. Place of III	jury - At home, farm, tc. (Specify)	street, tactory, of	ice		Location (Str City or Town,		ber or Run	al Route Number,	
To the Hospital or Attention within 24 Hours after deall within 24 Hourseld Director: completely filled in by the Medical Certifical		hysician: To the best miner: On the basis of and manner s	t examination and/or								
Vithin To the complex complex Me	29b. Signature and title of certifier	8		29c. Lie	ense number		29	d. Date signe	d (Month,	Day, Year)	
	1K Thu	M	Ŋ	ME	6364	14	M	AY 31,	2000		
C	30. Name and address of person who Kenneth M	completed sause of	1	e, Print)	nary		ine	Walte	- Re	ed Amo	
State	31. Date filed (Month, Day, Year) JUN 0 1 20	32. Regist	rar's Signature	hoos	Ma						



1. Decedent's Name (First, Middle, Last) **Physician** ZELDA MARY BOYD GOVAN /Medical 4a Facility Name (If not institution, give street and number) Examiner Hospital Sinai Baltimore 04 5. Social Security Number 217–24–7668 7. Age (In yrs. last birthday) 70 Yrs. **Funeral** 1□ M 2XX Director Usual Residence of Decedent 10a. State 10b County MD. N/A Director 10e. Street and Number 745 POPLAR GROVE STREET

10c. City, Town or Location BALTIMORE 10f. Zip Code

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Year

Days

Months

10d. Inside City Limits 1 XXes 2 □ No

10g. Citizen of What Country?

28,2000

N/A

1929

4c. County of Death

3. Time of Death

9. Birthplace (State or Foreign Country)

4:24 PM

11. Marital Status 1 Never Married 2 Namied 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 750 If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

21216

14. Race - American Indian, Black, White, etc. Specify: BLACK

USA

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PRIVATE FAMILIES

16b. Kind of Business/Industry

6TH GRADE

Funeral

Completed

8

should be filed within 72 hours after on Mental Hygiene. marked other than "natural", or Her

ies 1 and 2 should be fill of Health and Mental H filem 27 is marked oth

permit. Pages 1 Department of H Important: If its any Injury or ott once.

Physician

Examiner

anding physician and use as the bunal-transit

signed I

page 2 s

certificate

within 24 hours a To the Funeral D completely filled Hospital

Physician/Medical Examiner

þ

Be Completed

2

Medical Certification:

/Medical

17. Father's Name (First, Middle, Last) SAMUEL F. ISHWAY SR.

18. Mother's Name (First, Middle, Maiden Sumame) LEOLA WHITENER

2. Date of Death

8. Date of Birth (Month, Day, Year)

27,

Month

OCT.

4b. City, Town, or Location of Death

Baltimore

If Under 24 Hrs.

19a. Informant's Neme/Relationship (Type, Print)

BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4102 GLEN HUNT ROAD BALTIMORE, MD. 21229

SAMUEL ISHWAY, JR.

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

DOMESTIC

20c. Location - City or Town, State

1 Sprial 2 Cremation 3 Removal from Stete
4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens

GARRISON FORREST VETERANS JUNE 2 OWINGS MILLS, MD.

arry

22. Name and Address of Facility NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY BALTIMORE, MD. 21216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the cause of the cause

Immediate Cause (Final disease or condition resulting in death)

pneumonia

Approximate Interval Between Onset and Death day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

Due to (or as a consequence of):

that initiated events resulting in death) Last

23b. Did tobacco use contribute to the cause of death?

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 No 1 ☐ Yes 2 10 No

25. Was case referred to medical 1 Yes 2 No

Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Menger of Deeth 1 Netural 5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

Belvedere Avenue, Baltimore, Maryland 21215

29a. Certifier

2 Accident 3 Suicide

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier ear

sonia M. Benn

MD

Kas-000

May 28, 2000

State Registrar

31. Date filed (Month, Day, Year) UN 0 1 2000

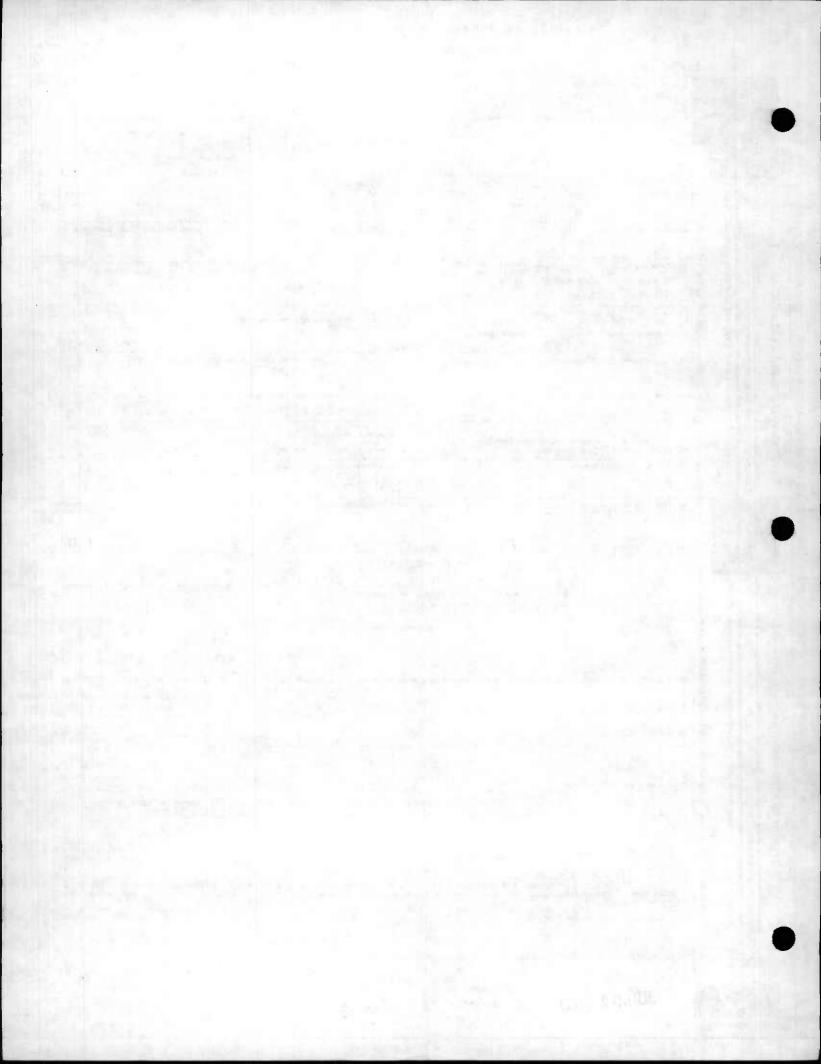
MO 2401 32. Registrar's Signature

West

Thown Baitimore, Patient Box 68760.

The law requires that the death certificate be axecuted P.O. Records, Division of Vitai al or Attending Physician: The safter death.

In Director: After this certificated in by the funeral director, pages of the funeral director director, pages of the funeral director



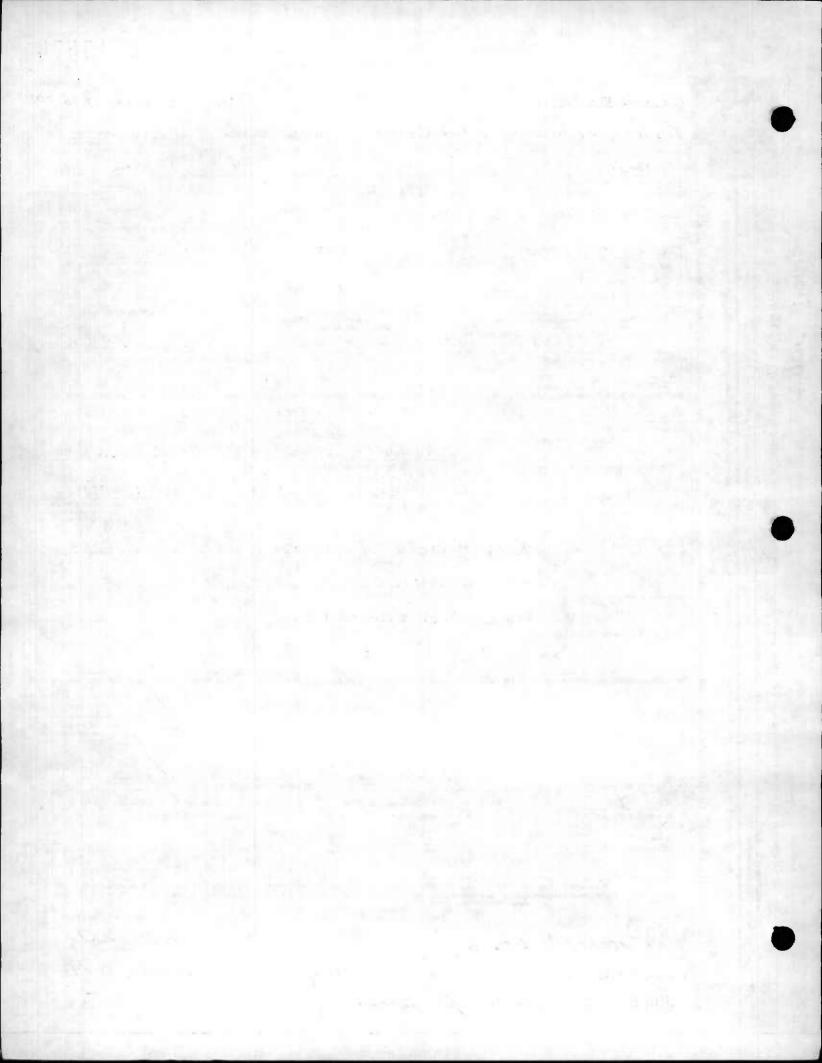
State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth as accord Month Physician 9:12 pm DORIS EILEEN GREGOR 4b. City, Town, or Location of Death /Medical 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Franklin Square Hospital Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year)

June 29, 1917 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Hours 1 M 2 VF Vre Maryland 217-18-3339 Director Usuat Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exerciser must be notified at 1 ☐ Yes 2 No Director Maryland Abingdon Harkord 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 182 Glen View Terrace 21009 U.S.A. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Deles: 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pemit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if frem 27 Ia marked other than any injury or other traumatic avant. Elementery/Secondary (0-12) College (1-4or 5+) 4 years Buyer Baltimore City Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Aubrey Slade 2 Ruby Grove 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 182 Glen View Terrace, Michael S. Gregor Abingdon, MD 21009 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ACremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 15/29/00 Green Mount Crematory Baltimore. Maryland 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, 21. Signeture of Funerel Service Licenses 610 W. MacPhail Road, Bel Air, MD 21014 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. **Physician** tmmediete Cause (Final disease or condition resulting in death) /Medical · Respiratory 26 hours Examiner Due to (or as a consequence of): Examiner b. Hypotension certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initieted events resulting in death) Last and Due to (or es a consequence of): 68760 . Myocardial Infarction Physician/Medical the Due to (or as a consequence of) Box P.O. | 23b. Did tobacco use contributa to the cause of death? been signed by the s should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 20 No 3 Probably 4 Unknown Records, þ Completed 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 2 000 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: 8 25. Wes case referred to medical 26. Placa of Deeth (Check only one) 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Menger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Metural 5 Pending Unerel Director: Attention of the filled in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RD 191783 May 25 2000 recepto P.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21037 9000 Frankin Square Drive Baltimore Maryland DR Kevin Brewster 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State JUN 01 2000 ones Registrar DHMH 16 Rav 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month 27 Day May 2000 7:40 PM Sulvia Grotsky 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Havre de Grace Harford Memorial Hospital Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Dec 10, 1916 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1□ M 2□F Months 112-10-8932 83 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Harkord Maryland Bel Air 10f Zin Code 10g Citizen of What Country? 10e. Street and Number 21014 U.S.A. 1103 Jade Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Stetus 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Factory 9th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ida Drellich Harry Ceblauch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Jeffery N. Grotsky (Son) 1103 Jade Drive, Bel Air MD 21014 20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5/30/00 Clifton, New Jersey Eastridge Lawn 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of rosclerofi Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) yers, a Due to (or es e consequence of): 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA 27. Mapner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner 68760. Box Vital ö Division

Physician/Medical

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Completed

1935

100/10

Physician

/Medical

Examiner

Directo

Funeral

Director

GROTZKY,

Registrar

State

diresto 31. Date filed (Month, Day, Year)

29a. Certifler

FACE

use of death (Item 23a) (Type, Print) 32. Registrar's Signature

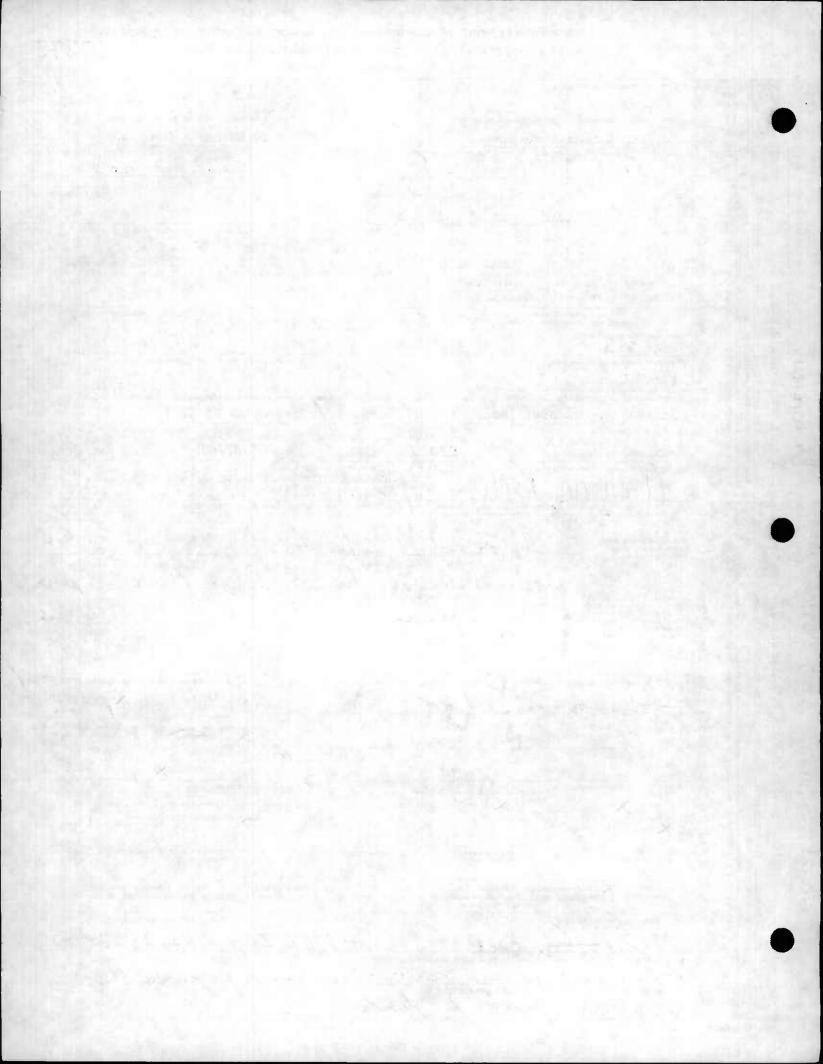
29c. License number

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and pleca, and due to the cause(s) and manner stated.

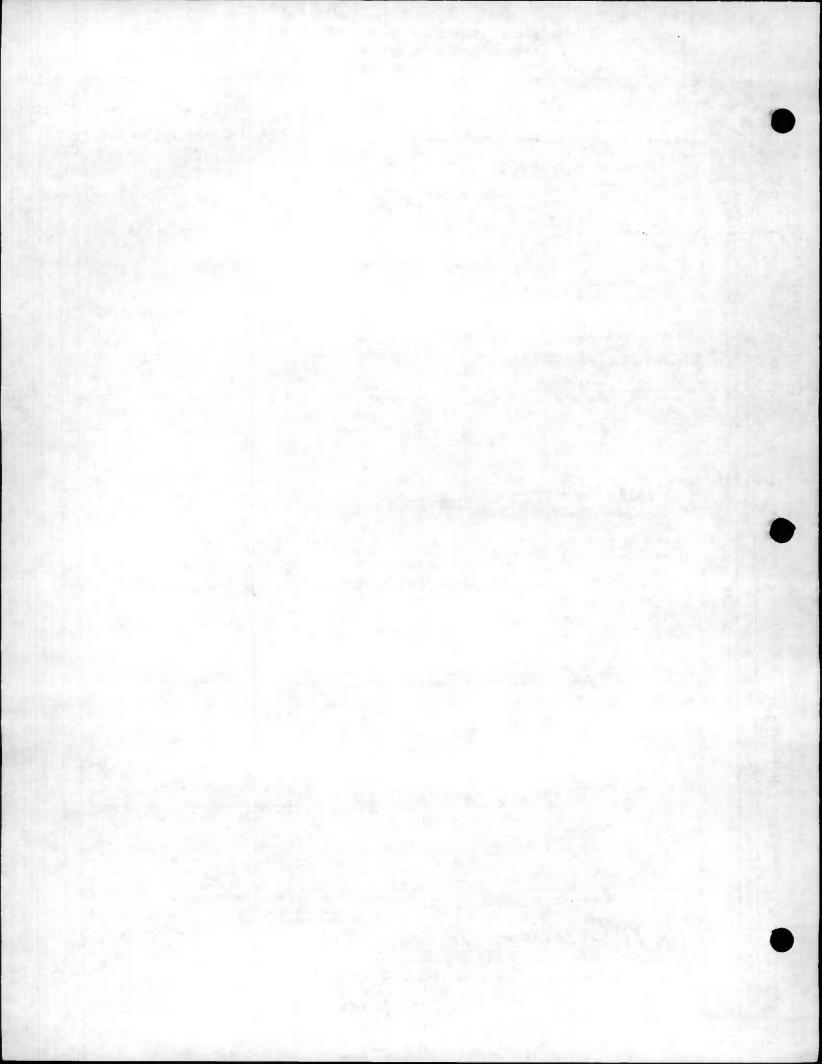
29d. Date signed (Month, Dey, Year)

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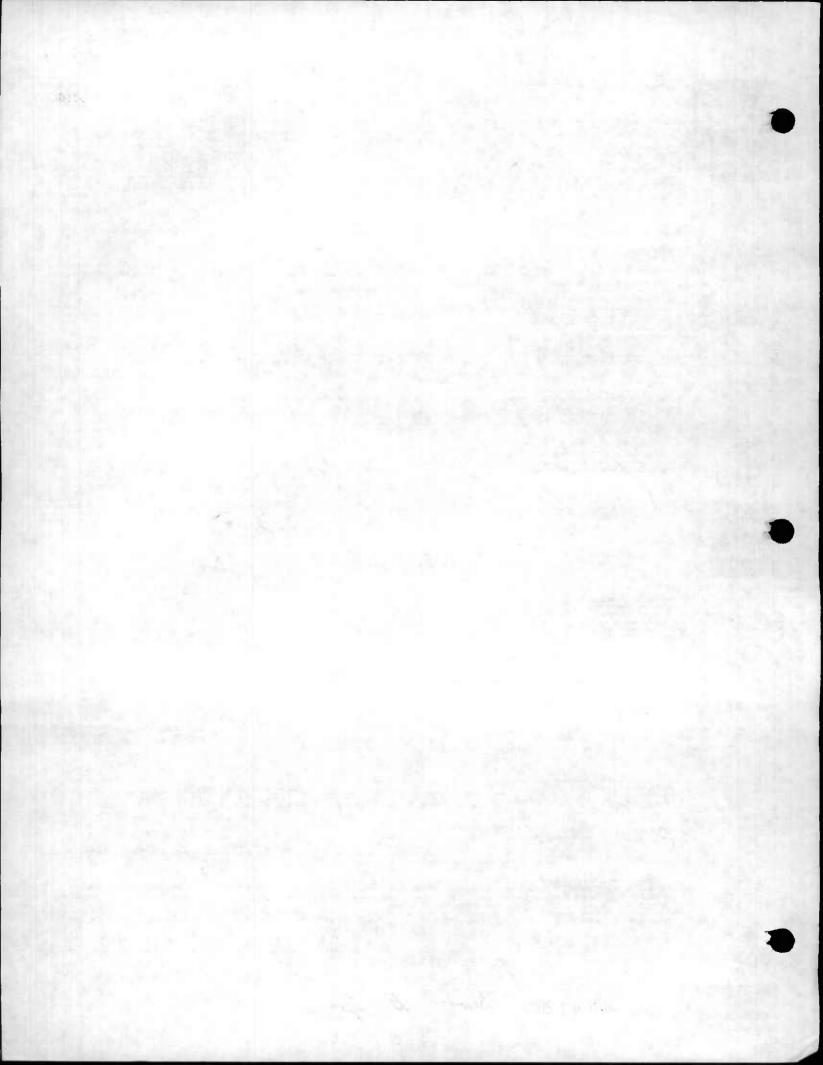
State of Maryland / Department of Health and Mental Hygiene 00 | 7476

			Certificate o	f Death	R	eg. No.		
	1. Decedent's Nama (First, Middla, Las	"			2. Data of Daal Month	h Day	Yaar 3.	Time of Death
sician edical	Margaret Kather	ine Greenborn	n		May			1:13 pm
minor	4a Facility Nama (If not institution, giva	street and number)		4b. City, Town, or Lo		4c. County		
	Franklin Square	Hospital C	enter	Roseda er If Undar 24 Hrs.	1e	Bal	timo	re
ai or	5. Social Security Number 6. Se 220-30-4332	7. Aga (In yrs.	last birthday) If Under 1 Ye Yrs. Months De	8. Date of Birth (Month, Dey, Yaar) March 9, 1937 Maryland 9. Birthpleca (State or Formation Country) Maryland				
1000	Usual Rasidence of Decedent 10a. Stata 10b. County	10c City	y, Town or Location				104	Insida City Limits
			7					1 ☐ Yes 2 ☑ No
Directo	Maryland Baltimo	re	White Ma					
<u>a</u>	5811 Lytle Road		10f. Zip Code	21162		0g. Citizan of V U.S		
by Fur	11. Marital Stetus 1 □ Nevar Maπiad 2 ☒ Maπied 3 □ Widowed 4 □ Divorced	12. Was Dacedant Evar In U, Armed Forcas? 1 ☐ Yas	S. 13. Was Decedent of If Yas, specify C	of Hispanic Origin? (Speuban, Maxican, Puerto No Specify:	city Yas or No- Rican, etc.)		e - Amaricen II ck, Whita, etc.	rite
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To 8	Francis K. Schm	itt		Margaret	: A. R	omeo		
	19a. Informant's Neme/Relationship (7)	ype, Print)	19b. Mailing Address (Stre	et and Number or Rura	I Routa Number	City or Town,	State, Zip Coo	de)
3	Charles R. Greenb	orn (husband)	5811 Lytle 1	Road. White	Marsh.	MD 21	162	
200 0	20a. Mathod of Disposition 1 Buriat 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specify,	20b. P	Plece of Disposition (Nama of ematary, cramatory or other partlens of Fait	place)		20c. Location -		
0000	21. Signeture of Funerel Service Licens		22. Nama end Ado	t.			21236	
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cian		d						
/ Physician	Part II. Other eignificant conditions co	ntributing to death but not rasi	ulting in the underlying couse	givan in Part I.	236. Did 10		3 Probabl	e cause of death? ly 4 ☐ Unknown
Be Completed by Physician/		-77			24a. Wes e		availat	autopsy findings ola prior to etion of cause
omple	Karaman III	had been			1)1/1	es 2□No	of daa	th?
0	25. Was cesa referred to medicel			26 Place of Dool			74	20 20 100
Ø O	axaminar?	Hospital: 1 Inpatiant 2	ER/Outpatient 3 DOA	26. Place of Deatl Other: 4 Nursing Ho			as (Casaita)	
-	27. Mannar of Death	/ / /			28d. Describe h			
Medical Certification: To Be Comp	1 Natural 5 Panding investigation 3 Suicida 6 Could not be	28a. Data of Injury (Month, Day Year)		☐ Yas 2 ☐ No	28f. Location (S	treet and Numb	per or Rural Ro	outa Number.
Cert	4 ☐ Homicide detarmined	building, afc. (Specify	y)		City or Tow			
dical	29a. Cartifiar (Check only one) 1 Certifying Phy 2 Medical Exami	elclan: To the best of my kno- ner: On the basis of axamina and mannar stated.	wledge, death occurred at the tion and/or invastigation, In m	a time, data and place, y opinion, death occurr	and due to the c ed at the time, d	ause(s) and ma ete and place,	anner as state end due to the	d. o cause(s)
2	29b. Signature and titla of certifier		29c. Lice	ensa number	2	9d. Data signe	d (Month, Day	r, Year)
3 -1	N/// W/2 2 4	un m	1) DE	3694		5/2	10/1	0
	110sua	110		3011		9/0	4/0	
	30. Nama and address of person who co DR Daniel Shinne	ompleted cause of death (Item			Itimass	440	712	37



State of Maryland / Department of Health and Mental Hygiene 171, 77

		dent's Name		Last)					TNI			2. Date of Dea		- Nant	3. Time of Death	
Physician /Medical	ETI	.'A	K				HOF	RNSTE	IN			MACY	29y 20	OQQ _a r	10:40AM	
Examiner	4a Faci	ility Name (It ERED L	f not Institution, I	give street en FPIKE	nd number) ESVILLE	Ξ				4b. Cify, To BALT		ocation of Death	4c. Count			
uneral rector		Security N 5-28-7		6. Sex 1 □ M 2	7. Age	(In yrs. las 92	t birthdey) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, De) JUNE 1	1907	9. Birthp Cour MD	piece (Stete or Fore htry)	
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2 2	10e. Str	reet and Nur						10f, Zir, 21	Code				10g. Citizen of What Country?			
her must be under all funeral f		B PARK	HEIGHT				21215 13. Wes Decedent of Hispanic Ortgin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Ra	USA ca - Americ	can Indien,	
- B	3,5		ied 2 Merried 4 Divorced	d 1 G	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Wes Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No					an, Mexica Specify.		Rican, etc.)	100	ock, White,		
"naturel", ed cel Exe leted by		(Spec	15. Decedent's hity only highest	Education grade compl	ducation 16e. Decedent's (Give kind (Give ki			lent's Usua kind of wo	al Occup	etion during mos	st of work	ing	16b. Kind of B	Business/In-	dustry	
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important: If I any injury or one	22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD PIKESVILLE, MD															
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State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Day Month **Physician** 220 PM 30 WOODROW HILL Tay 2000 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE SPECIALTY N/A DEA ION HOS PITAL AND HOTE If Under 24 Hrs. If Under 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Months Hours 1 XX 20 F 71 230-22-6446 **Director** AUG 6, 1928 VA Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 25s-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No MD. N/A BALTIMORE Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3816 GELSTON DRIVE 21229 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 11. Meritel Stetus parmit. Pages 1 and 2 should be filed within 72 hours aftar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic events. Vor Yes 2 ☐ No Pres, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2□ No Specify. Specify BLACK à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11TH GRADE PLATFORM MAN BETHLEHEM STEEL 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be GEORGE HILL LENA WILKES 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HALLIE V. HILL WIFE 3816 GELSTON DRIVE BALTIMORE, MD. 21229 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurle 2 Cremetion 3 Removal from Stete 4 Donetion 5 Other (Specify) 3 BALTIMORE, MD. LOUDON PARK CEMETERY JUNE 21. Signeture of Funerel Service Lie 22. Neme end Address of Fecility NUTTER FUNERAL HOMES, INC 2501 GWYNNS FALLS PKWY BALTIMORE, MD. 21216 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceusa on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Ceuse (Final Retromolar 4 month 8 Trigone Concer disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): certificate be execu Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of) USB as attending | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? the been signed by t should be detach detach 1 Yes 2 No 3 Probably 4 TUnknown amoxic encephalopethy seizures dusardon þ 24b. Were eutopsy findings availeble prior to completion of cause of deeth? 24a. Was en autopsy Completed 20 No 1 Yea 21 No 1 ☐ Yes this certificate Division of Vital or Attending Physician: director 25. Was case referred to medical å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Lo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Manger of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Investigation after death. Director: Aft 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a 24 hours a 29a. Certifier (Check only one) 🗺 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. Medical completely 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. To the To the To the I 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 30494 5 130100 * MESAI my Deaton moderal conter all south chalos St Baltimore my VIV3 0 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State ook Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent'a Name (First, Middle, Last) Month Year **Physician** MARGARET R. HUDSON 10:48 PM 05 29 00 /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner OF MARVLAND MEDICAL SUSTEM BALTIMORE UNIVERSITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) NORTH CAROLINA 7. Age (In yrs. last birthday) 6. Sex 8. Dete of Birth (Month, Dey, Year) Sex 1□M 2XF **Funeral** Hours Deys Yrs. 71 Director APR 5 1929 213-74-7655 Usual Residenca of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or flams 23s or 25s-f shor XX Yes 2 No Directo MARYLAND N/A BALTIMORE CITY and Mental Hygiene. is marked other than "natural", or hams 23s or 26s-f numetic event, the Medical Examiner must be notifi-10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2033 W. SARATOGA STREET 21223 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? XXXes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 22 filled within Elementery/Secondary (0-12) College (1-4or 5+) 12th grade unemployed N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental N permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumetic ev 2 PATSY PARKER unknown 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2033 W SARATOGA STREET BALTIMORE, MARYLAND 21223 Patsy A. Whitby/Daughter 20b. Place of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, State Date 20e. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 5-30-00 BALTIMORE, MARYLAND 21. Signature 22. Name end Address of Facility Wollen WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Past. Fine the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final RETROPERITONEAL disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed burial-transil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): physician a Box 68760. Physician/Medicai Due to (or es e consequence of): Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? P.O. signed by t 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown RENAL FAILURE Records, by 24b. Were autopsy findings eveileble prior to plnods 24e. Was en autopsy performed? Completed Deen CORONARY ARTERY DISEASE completion of cause of death? has page 2 ils certificate h I director, page of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify) 1 Yes 2D No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident Division Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attendir nours after death. neral Director: A/ / filled in by the fu death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours a To the Hospital within 24 hours a To the Funeral C completely filled Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 05/29/00 13mm 110 PS 13365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. BROWN 22 NOTETH GREENE STREET, BALTIMORE, MD 21201 M.D. JOLENE

State Registrar HMH 16 Rev 6/95

31. Date filed (Month, Day, Year)
JUN 0 1 2000

32. Registrar's Signature

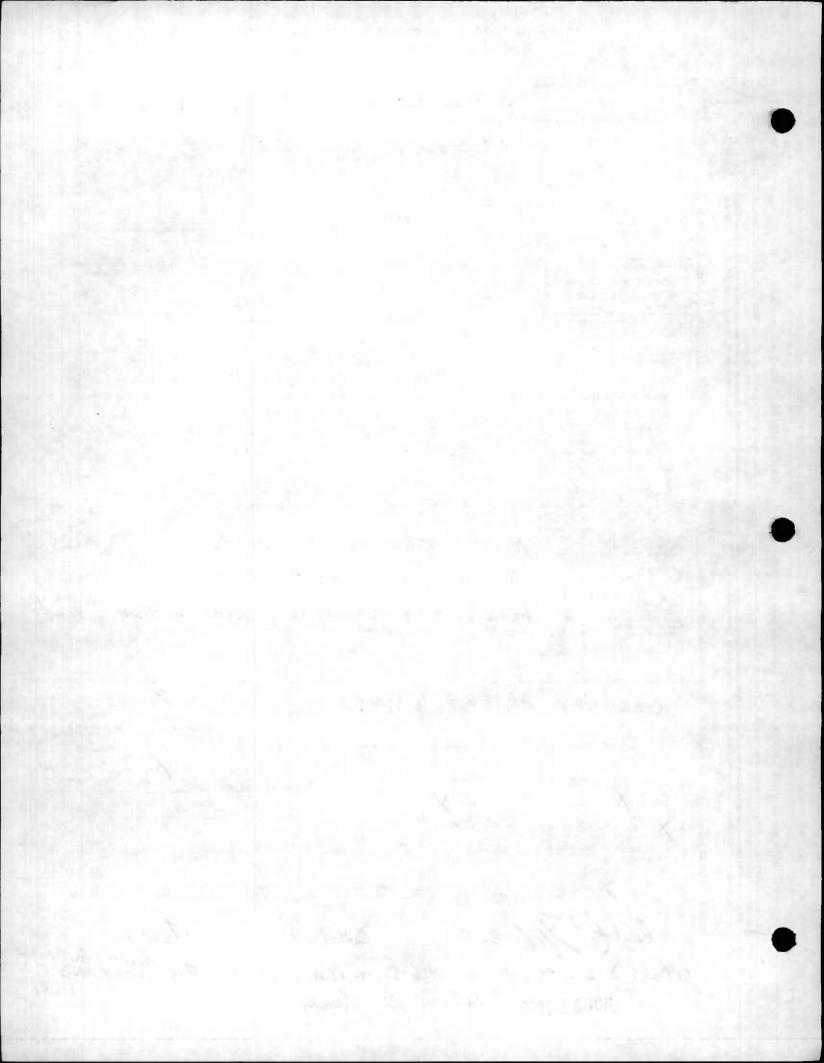
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Eulalar N. Hockhalter 19 3:29 P.M. May 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor Hospital Center ff Under 1 Year | If Under 24 Hrs. | Hours | Min. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2図 F Yrs 220 22 7368 Director 83 Sept. 28,1916 South Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 Seward Avenue 238 21225 U.S. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2⊠ Married Saltimore, Maryland 21215-0020 natural, or 1 Ves 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry fled within Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Tailor Shop 6th permit. Pages 1 and 2 should be file Department of Health and Mental Hyg amplicated other any injury or other traument 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Minnie Lelar Cartee John Bunion Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 217 Seward Avenue Adolph Hockhalter / Husband Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 5/24/00 Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) ACUTE GASTIZOINTESTINAL BLEET HOURS Examiner Due to (or as a consequence of): ACUTE BOWGE OBSTRUCTION Physician/Medical Examiner ettending physician and for use as the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence ot): HEREDITARY HEMORRHAGIC TELANGIECTASIA Box 68760, Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ARTERY signed to Records, à 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 1 24 hours after deeth. Funeral Director: After this cartifica stely filled in by the funeral director, p 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturat 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number. City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner steted. 29a, Certifier 29b. Signature and title of contiller 29c. License number 29d. Date signed (Month, Day, Year) Cour 5/22/00 1406 Scott CRAIN HWY- HOW MARKAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14.0. - 21606 0 32. Registrar's Signature 21061 31. Date filed (Month, Day, Year) State JUN 0 1 Registrar 2000

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Colette C. Hahn May 27, 2000 12:28 PM 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore 8729 A Old Harford Road Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) Months 1 ☐ M 200 F 78 Yrs. 220-14-2990 April 5, 1922 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. toside City Limits Baltimore 1 Yes 2 No Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 U.S.A. 8729 A Old Harford Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indian, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 Yes 2 No Specify: White Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Own Home Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) James J. Streb Catherine H. Kunkel 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Gerard J. Hahn 9428 Seven Courts Drive, Baltimore, MD (son) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Buriat 2 ☐ Cremation 3 ☐ Removet from State 5/31/00 Baltimore, Maryland Most Holy Redeemer Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signeture of Funerel Service Licensee mark 9705 Belair Rd., Baltimore, MD is thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, ise on each line. Approximate Interval Between Onset and Deeth Immediate Ceuse (Final CARCINOMA OF the LUNG disease or condition resulting in death) Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medicat examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 27. Menger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Physician/Medical Examiner physician s the burie Box 68760 98 by Completed Be Medical Certification: To this

The law requires that the death certificate be executed To the Hospital or Attending Pl within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funera

Physician

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Examiner

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death in nent of Health end Mentel Hygiene.

Nem 27 is marked other other treumatic event,

nt of Health e I: If item 27 is 7 or other tree

Department of Important: If any injury or

Physician /Medical

Examiner

Baitimore, Maryland 21215-0020

P.0. Records, Division of Vital

State

DHMH 16 Rev 6/95

Registrar

31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

29e. Certifier

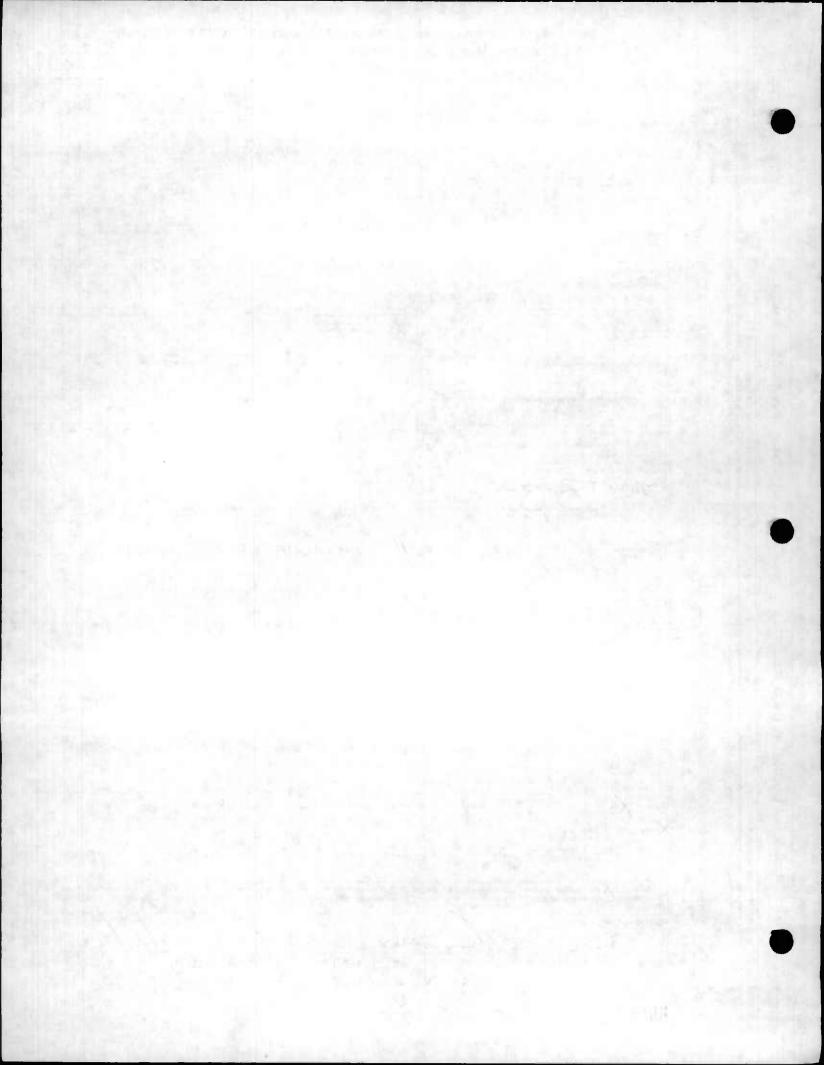
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29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month), Dey, Year) 30 2005

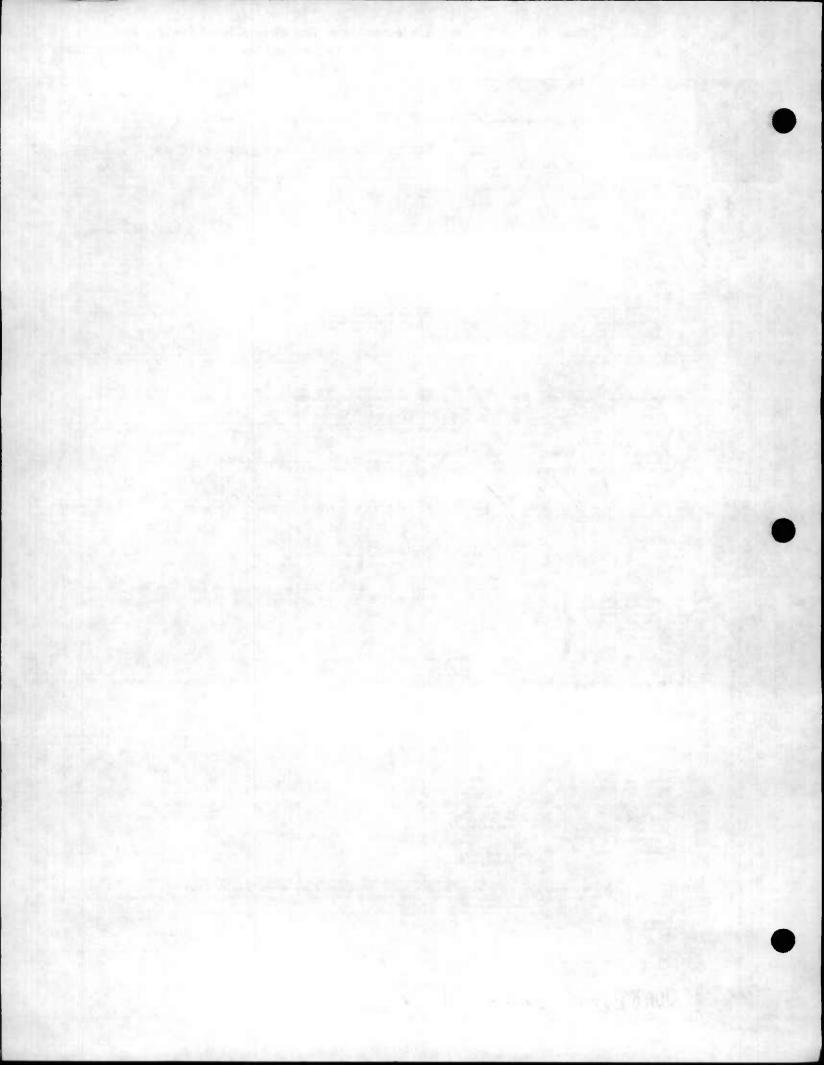
30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print) FISHER BRIC Re 2360 Wes 32 Abgistrar's Signeture



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Physician	Decedent's Neme (First, Middle, La.	s) Thomas	s 0.	Jo	nes				2. Dale of Des Month May 27	Day	Year	3. Time of Death 4:00 PM		
/Medical Examiner	4a Facility Nama (If not institution, give	e street and number,)			-	lb. City, To	wn, or Lo	cation of Death		ol Death	4.00 FM		
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State of Maryland / Department of Health and Mental Hygiene 00 17483

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death CLARENCE C. JONES Month **Physician** MAY 14:45 30 2000 /Medical 4a Facility Name (Il not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTTMORE N/A UNION MEMORIAL HOSPITAL 8. Date of Birth (Month, Dey, Year) If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days XXM 2DF 82 220-01-0994 Yes Director FEB. 16, 1918 MD. Usual Residence of Decedent the Meryland 10a. State 10b. Count 10c. City, Town or Location 10d. toside City Limits a or 28a-f show Show BALTTMORE N/A MD. Yes 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 USA 3045 SEAMON AVENUE Framiner meet Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ld be filed within 72 hours after de ental Hygiana. ked other than "natural", or flams ic event, the Medical Exemplement NOYes 2 No fi Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify. Specify: BLACK à 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 US POSTAL DEPT. POSTAL CARRIER permit. Pages 1 and 2 should be file Department of Haalth and Mental Hy, Important: If fem 27 is marked othe any injury or other traumatic event, page. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be PAUL JONES SUSAN CARTER 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN I. JONES COUSTN 7952 ANDORICH DRIVE SEVERN, MD. 21144 Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burlal 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) GARRISON FORREST VETERANSJUNE 6 OWINGS MILLS, MD. 22. Nama and Address of Facility NUTTER FUNERAL HOMES, INC. 21. Signature of Funaral Service Licenses Herbert & natter 2501 GWYNNS FALLS PKWY BALTIMORE, MD. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Intervat Between Onset and Death Physician tmmediate Cause (Final disease or condition resulting in death) /Medical ACUTE ANTERIOR MY OCARDINE INFARCTION (CARDISCOLIC 24 hrs Examiner SHUCK Due to (or as a consequenca of): 48 hrs Examiner PAROKISMAL ATTUR FIBRILLATION The law requires that the death certificate be sxecuted burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical tha Due to (or as a consequence of) 88 Pert If. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. 2 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION, CAD , CHRONIC (ZEINAL PAILLRE signed t Records, PV 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed (C) RENAL MASS SIP EMPERCHOLESTERO LEMAIN, page 2 hes 1 ☐ Yes 2 ☐ tvo NEGHRECTOMY 1 Yes ANO cartificate Vital Physicisn: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1□ Yes 28 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To o Aftar this funaral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Division Attending Neturel 5 ☐ Pending 1∏Yes 2∏No investigation death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 ☐ Homicide 6 filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. edical complately (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. To the To the F 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WEDICAL 30 AT2438964 2000 (LESINON) Mom mal 30. Nama and address of person who completed cause of death (Item 23s) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

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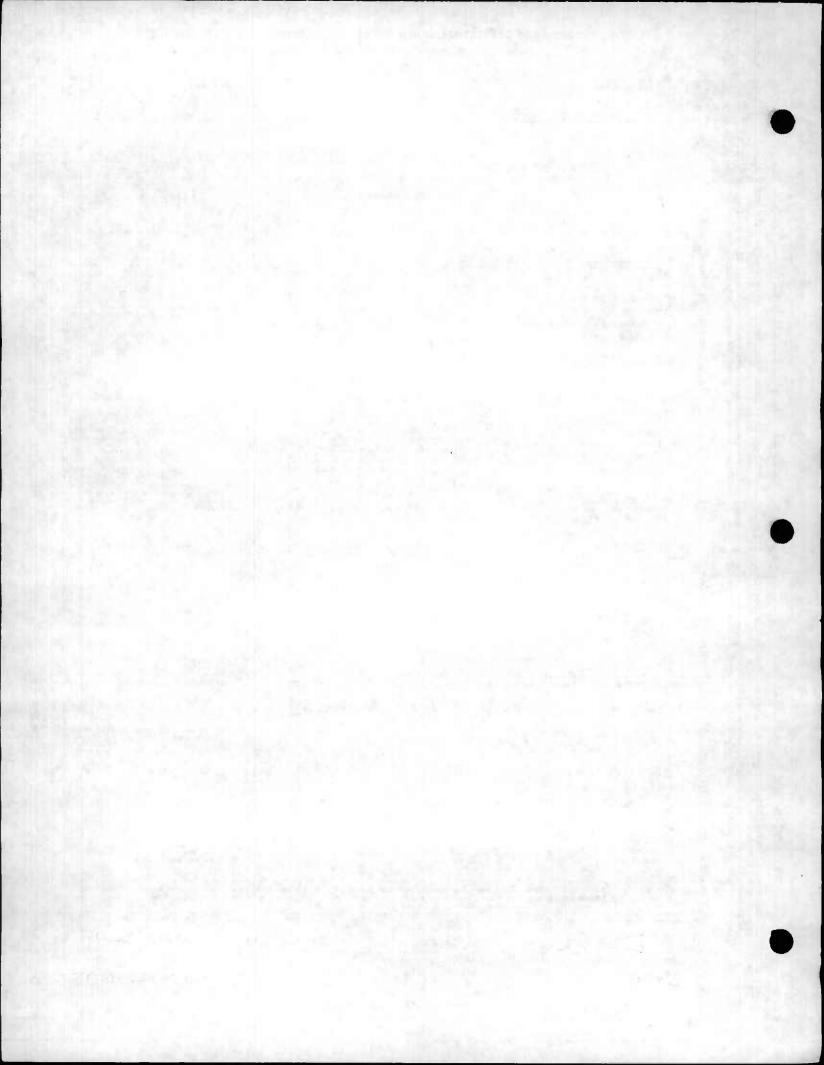
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32. Registrar's Signatura



	1. Decedent's Nen	ne (First, Middle, La	st)		001	tificate c	Doddi	2. Date of D				3. Tima of Death	
ician	CYNTHIA :	DENISE JO	HNSON					Month 7	Day 26		Year	08:45	
dical niner		(II not institution, giv		nber)			4b. City, Town, o	r Location of Dea		County o		00.45	
iiiiiei	ST. AGN	IES HEA	LTT CA	RG			BALTI	MORE		I/A			
	5. Social Security (213-72-5	Number 6. S			i. last birthday) Yrs.	If Under 1 Ye Months Da	ar If Under 24 Hr	s. 8. Dale of B	irth lay, Year)		9. Birthpiaco Country)	e (State or Foreign	
FE)	Usuel Residence of 10a. Slale	10b. County		10c. C	ity, Town or Lo	cation						Inside City Limits	
tor	MD.	N/A		190		BALTIMO	RE		1 Ves 2				
ai Director	10e. Street and Nu 4205 FAI	mber RFAX ROAD				10f. Zip Cod 21	216			0g. Citizen of Whal Country? USA			
by Funeral	11. Merital Stelus 1 Never Man 3 Widowed	ried XXMerried 4 Divorced	12. Wes Dece Armed For 1 Yes If Yes, Giv Year or Da	rces? 2)(I)(No e		Was Decedent of Yes, specify C	of Hispanic Origin? (Juban, Mexican, Pue No Specify:	Specify Yes or Norto Rican, etc.)			- American c, White, etc. BLA		
Be Completed	Elementery/Seco	15. Decedent's E- cify only highest gra ondary (0-12)	fucation de completed) College (1	-4or 5+)	(Give	OO NOT use rei	ne during most of w	orking	16b. Kir	nd of Bus	siness/Indus	lry	
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once. To Be Co		□ Cremetion 3 □		Stete	Place of Dispo- cemetery, cren	sition (Name of natory or other)	place)	Date	Y		City or Town,	, Stele	
		5 ☐ Other (Specif		M		CEMETE	description of Parallity	MAY 31 LANSDOWNE, MD.					
	21. Signelure of Funerel Service Licensee 22. Neme and Address of Facility 25. Neme and Address of Facility 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 25. Neme and Address of Facility NUTTER FUNERAL HOMES, I 26. Neme and Address of Facility NUTTER FUNERAL HOMES, I 26. Neme and Address of Facility NUTTER FUNERAL HOMES, I 26. Neme and Address of Facility NUTTER FUNERAL HOMES, I 27. Neme and Address of Facility NUTTER FUNERAL HOMES, I 28. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERAL HOMES, I 29. Neme and Address of Facility NUTTER FUNERA												
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edicai	Sequentially list on if any, leading to in cause. Enter Unde Cause (Disease or that initialed event resulting in death)	onditions, mediate entying injury s Last	c		or as a consequ								
sicia	Part II. Other signit	ficant conditions c	ontributing to de	ath but not re	sulting in the un	deriving cause	given in Part I.	23b. Did	1 tobacco	use cont	tributa to the	e cause of death?	
by Physician/M		positive,	AIP						Yes 2			ly 4□Unknown	
Completed I	HEPAT	1715 B						24a. Wa peri	s an autop lormed?	sy	aveilal	autopsy tindings ble prior Io letion of cause ath?	
					25 [16]			10	Yes 20	No No	1 🗆 Y	es 25 No	
To Be	25. Wes case refer axaminer? 1 Yes 2		Hospitel: 12 Ir	patient 2] ER/Outpatien	3□ DOA	Other	eath (Check only Home 5 Res		6 DOther	r (Specify)		
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Certific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	buildin	g, etc. (Speci	fy)	et, fectory, offic			own, Stete))			
edical	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the la liner: On the ba- and mann	sis of examina	owledge, death ation and/or inv	occurred el the estigation, in m	time, date and plac y opinion, death occ	e, end due to the curred at the time	e cause(s) , date end	end man plece, ar	nner as stele nd due to the	e ceuse(s)	
Z	29b. Signature and	title of certifier	DICAL PA 136 , #28	ESIDEN'	1 .		2588			-	(Month, Day	· · · · · · · · · · · · · · · · · · ·	
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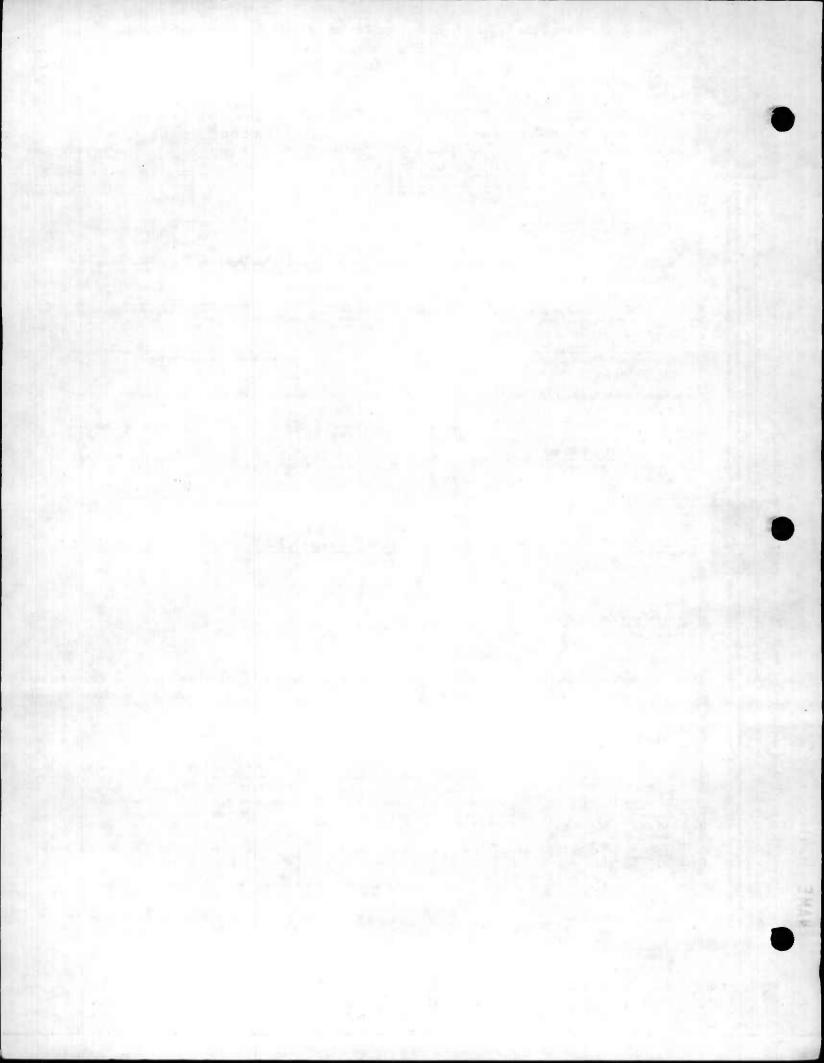
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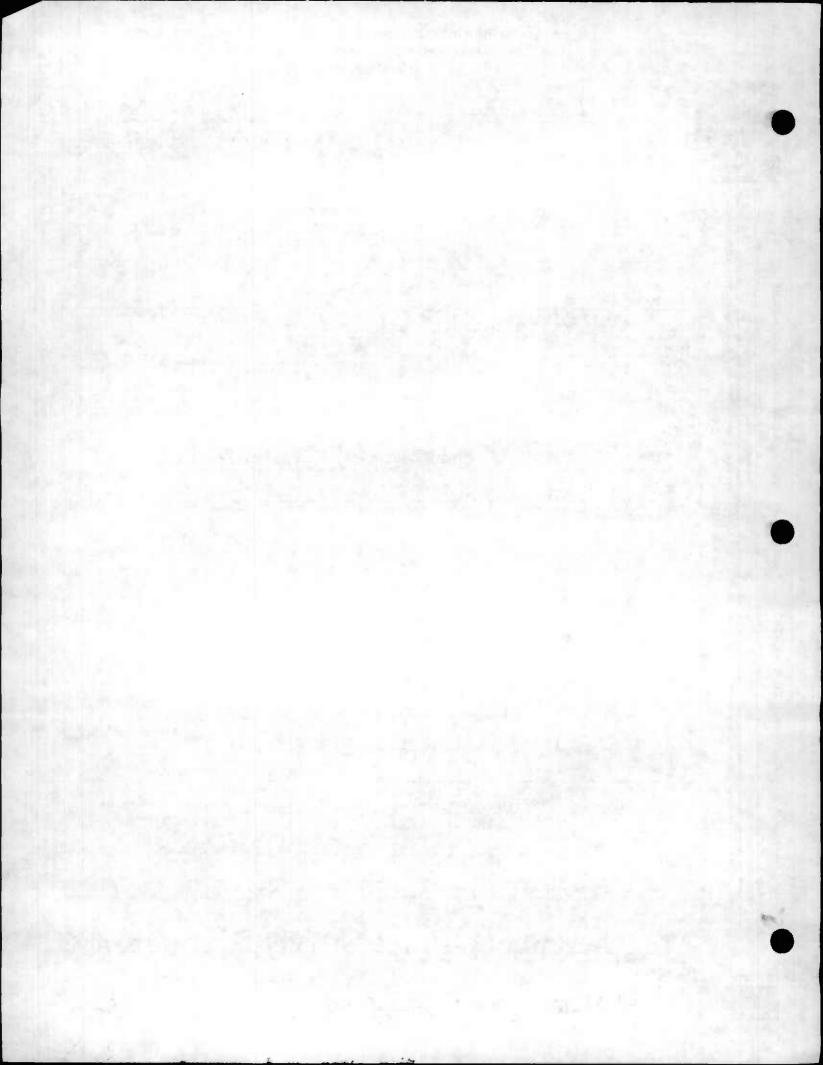
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yaar **Physician** MYRA MARIE JACKSON May 21,2000 11:00AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Baltimore Kosedale Franklin Square Hospital Center If Undar 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Date of Birth (Month, Dey, Year) **Funeral** Days Hours Months 1□ M 357F 41 218-64-1284 Director DEC. 22, 1958 Usual Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XX yes 2 No N/A BALTIMORE Director MD. tems 23s or 28s-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21201 USA 116 N. POPPLETON STREET Funeral Wes Decedent of Hispanic Origin? (Specify Yes or Notil Yes, specify Cuban, Mexican, Puerto Ricen, atc.) Race - American Indian, Black, White, etc. Wes Decedent Ever in U.S. Armed Forces? 11 Merital Status 1 Yas 2 YYO If Yes, Give Year or Dates: 1 Nevar Married 2 Married 8 On , Myrq Maryland 21215-0020 1 Yes 2 to Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RESIDENTIAL HOUSE MANAGER SELF PRIDE 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be ESTON JACKSON HANNAH WATSON son. Mental Health and N tem 27 is man 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SISTER 702 PENNSYLVANIA AVENUE BALTIMORE, MD. 21201 APT.5 TRINA M. WASHINGTON Item 27 Baltimore, 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State Department of P Important: If Ite 8 J May 26 Baltimore. ion Cemeter 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Address of Sacility NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY BALTIMORE, MD. 21216 mesi 23a. Part1. Enter the disease, or complication, that can sed the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause of mich line. **Physician** /Medical Immediate Cause (Final monary 2 Weeks disease or condition resulting in death) Examiner Examiner mbol mongry The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last a consequenca of): pue Box 68760. Metastatic physician ung ancer Physician/Medical the Due to (or as a consequance of): lor use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? P.O. 1) Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of ceusa of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attanding 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 24 hours after death. 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Hospital Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier etely (Check only one) To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier leaves ni May 21,2000

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Ye JUN 0 1 Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr Maria Greaves 9000 Franklin Square Drive Baltimore, MD 21237 32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17487 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death May 2000 55pm Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Center UBSIN9 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) if Under 1 Year 5. Social Security Number 6. Sex 1 M 2 SF Hours Days 9 Months 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2/200 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marilai Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Seculety social Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) lliam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 lanne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Description | 3 Removal from State Date 20c. Location - City or Town, Stale 4 ☐ Donallon 5 ☐ Other (Specify) Meadow Ridge Mem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evars Chapel of Memories Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 410 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1. Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier

P.O. Division of Vital Records. **Physician**

/Medical

Examiner

Director

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Completed

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Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours after death with the Merylen Department of Heelth and Mentel Hyglene.

Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinat must be notified at endes.

Physician /Medical

Examiner

attending physician end for use as the burial-transit

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edical Certification: To

Baltimore, Maryland 21215-0020

or Attending deeth. efter To the Hospital o within 24 hours of To the Funeral Di

DHMH 16 Rev 6/95

Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30, Name and address of person who co cause of death (item 23a) (Type, Print)

Gemore Maculand

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31. Dale filed (Month, Day, Year) JUN01 2000

32. Registrar's Signature

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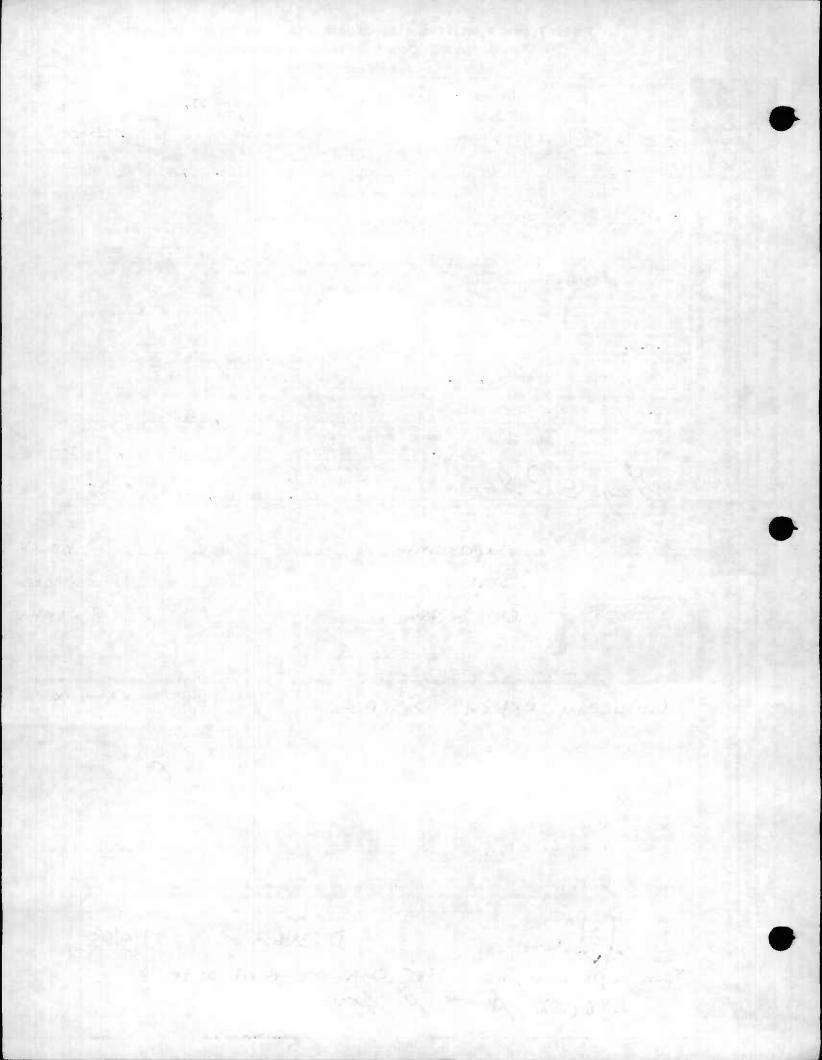
State of Maryland / Department of Health and Mental Hygiene 7488 Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Kewer Betty may 8:10 Am Lee 29 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Hospita Hopkins Johns If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 12, 19 Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 KF Min. Yrs. 213-36-0059 1938 Director 61 Usuai Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nems 23s or 28s-f show e filed within 72 hours after deeth with the Meryla al hygiene other than "natural", or flerna 23a or 28a-f show orth, the Medical Examine must be notified at 1 ☐ Yes 2 ☐ No Funeral Director DELAWARE SUSSEX SEAFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19973 U.S.A. RR2 BOX 326-18 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11, Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☒ Married WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 10 0 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) parmit. Peges 1 and 2 should be file Department of Heelth and Mantel Hy Important: if Item 27 is marked oth any Injury or other traumatic event Paces. Be HARRY S. TURNER EILEEN VON NODECK 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD L. KEWER, SR. / HUSBAND RR2 BOX 326-18, SEAFORD, DELAWARE 19973 20b. Pleca of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 6/2/2000 ELKRIDGE, MARYLAND MEADOWRIDGE MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE, BALTIMORE, MARYLAND 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical hours cerebral herniation Examiner Due to (or as a consequence of): Physician/Medical Examiner hours subarachnoil hemorrhoug The lew requires that the death certificate be executed attending physician end for use as the bunal-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760. thet initieted events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? hes 1 ☐ Yes 2 1 No 1 ☐ Yes 2 No this certificate al or Attending Physician: The setter deeth:

I Director: After this certificate of in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 ☐ Yes 2√ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours effer To the Funerel Direct completely filled in by 4 - Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature a/ld title of certified 4. de groot no May 2000 RES-000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 600 North Wolfe Street f. de Groot, m.o Johns Hopkins Hospital John State Registra

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Reg	J. No.	1/489					
Dharistan	1. Decedent's Name (First, Middle, La				2. Date of Death Month		3. Time of Death					
Physician /Medical		Dorothy Jea		May 27,		11:30 AM						
Examiner	4a Facility Name (If not institution, give	re street and number)	4b. City, Town, or Lo		4c. County of							
	Franklin Woods		t hirthday) If Under 1 Year	Rossvil			altimore					
Funeral	5. Social Security Number 6. S	IDM 2XF	Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1		Birthplace (State or Foreign Country)					
Director	Usual Residence of Decedent											
ath with the Maryland 23e or 28e-f show ust be notified at rel Director	10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits					
	Maryland Baltimore Edgemere											
	10e. Street and Number 10f. Zip Code 10g. Citizen of What Coun											
	8506 Maple Road	OF ENDINE	21219		tates							
her death or there 234 siner must.	11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of h If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto I	city Yes or No- Rican, etc.)		American Indian, White, etc.					
DZO on ath	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2₺ No	Specify:		Specify:	***					
thour thour	15. Decedent's E		6a. Decedent's Usual Occup	pation	16	Sh. Kind of Busi	White ness/industry					
1 21215-0 led within 72 ho lygiene. We then "netur it, the Medical.	(Specify only highest gra	ade completed)	(Give kind of work done life. DO NOT use retire	during most of working)	ng	16b. Kind of Business/Industry						
212 dwg dwg dwg dwg dwg dwg dwg dwg dwg dwg	G.E.D.	College (1-4or 5+)	Housewife			Own H	Iome					
ind to the the event,	17. Fether's Name (First, Middle, Last,			18. Mother's Name	(First, Middle, Ma	iden Sumame)						
Vlar Menta M	Norman Roland F	irestone, Sr.		Roseann	a Hochmu	th						
Maryland 21215-0020 d 2 should be filed within 72 hours at mand Mental Hyghest than "netural", or treumstic event, the Medical Example To Be Completed by 8	19a. informant's Name/Relationship (** '	19b. Mailing Address (Street	and Number or Rura	I Route Number,	City or Town, St	ate, Zip Code)					
CTN b	Mr. Charles Lab	,	8506 Maple Ro	oad Edgem	ere, Mar		21219					
10 m	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Stale	etery, crematory or other pla Andrews Cemet	1			- City or Town, State					
altimore, mit. Pages 1 a partment of Hes portant: If Hem. y Injury or othe	4 Donation 5 Other (Special	Dundalk	, Maryland									
Ba Populario	21. Signatum of Funeral Service Licence 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.											
	Dragn E.1	dalk, Ma	ryland	21222								
35	23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death. I one cause on each line.	r respiratory arres	it,	Approximate Interval Between Onset and Death							
Physician / /Medical	Immediate Cause (Final	2 hours										
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60, be executed ician and bunel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Cause (Disease or Injury Due to (or as a consequence of): 2 week 3 week											
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5 si sy si 5	that initieted events resulting in death) Last		of wee Us									
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al Records, P.O. Boy The law requires that the death or ale has been signed by the attend page 2 should be detached for us Completed by Physiciary	Part II. Other significant conditions of	ontributing to death but not resulting	ven in Part I.	23b. Did tobacco use contribute to the cause of deat								
P.O. that the debt by the detached detached	Coconacu	Artery T	Disease		1 🗆 Yas	Yes 2 No 3 Probably 4 Unknown						
dS, Figures that signed if the deli	Colombia	3. 1610	0,00,00	the second secon			an autopsy 24b. Were autopsy findings					
Cords v requires been sign should be				24a. Was an pertorm		evailable prior to completion of cause						
Rec elaw hest pe 2 s						-0	of death?					
Division of Vital Records, or attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be applicable.					/-		1 Yes 2 No					
Of Vita Physician: this certific ral director.	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient 3□ DOA Ott	26. Place of Death			(Canaita)					
Physic or this or eral direction To To	27. Manner of Death	28a. Date of Injury 28	Bb. Time of 28c. Inju		ome 5 ☐ Residenca 8 ☐ Other (Specify) 28d. Describe how injury occurred							
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To the to the com	29b. Signature and Mile of Cartifier				29	29d. Dale signed (Month, Day, Year)						
	1:11			53462		5/30/00						
10	30. Name and address of person who		Ba) (Type, Print)	ood Roa	150	- 100						
24.4	Jude C. Munes 31. Date filed (Month, Day, Year)	Ses, MD 18		DOG KOA	0 0017	e 100						
State Registrar	JUN 0 1 20	. 6. 442	B. Sparks									

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death MAY 31, Day Harriet Lewis 2000 9:20 AM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Knollwood Manor Genesis Eldercare Millersville Anne Arundel 7. Age (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 8. Data of Birth (Month, Day, Year) FEB 19, 1917 9. Birthplaca (Stata or Foraign Country) West Virginia 5. Social Security Number 578-03-9029 Days Hours 1 M 2 XF Usual Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yas 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 122 Hearne Ct., T-121401 USA 12. Wes Decedent Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Reca - American Indien, Black, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: White 34 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Bartender 17. Father's Nema (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Sumema) Unk. Mildred Bowers 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 312 Oakwood Rd., Edgewater, MD Aldona Smart/Friend 20b. Plece of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stata 4 Donation Metro Crematory, Inc.6/1/00 Baltimore, MD 5 Other (Specify) 21. Signatur of Funerel Sarvice Cremation Society of Maryland, Inc. Gregorchik Edward 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onsat and Death Immedieta Causa (Final eosis diseasa or condition resulting in deeth) Dua to (or es a consequance of): neumonia Dua to (or as a consaquance of): Due to (or as a consequance of):

Physician /Medical Examiner

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To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

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page 2 has

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Itam 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic avant, the Medical Examiner must be notified at

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72 hours after

e filed within 7 Il Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any Injury or other traumatic avant

altimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to Immadiata cause. Entar Undarfying Cause (Disease or injury that initiated events resulting in death) Last

Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? LUSIVE

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1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy performed?

26. Placa of Daath (Check only ona)

2 No 1 ☐ Yes 2 ☐ No

25. Was casa referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar:

Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 28a. Data of Injury (Month, Day Year) 28b. Tima of tnjury 28c. Injury at Work? 28d. Describe how injury occurred

5 Pending investigation 2 Accident 3 Suicide

1 Yas 2 No 6 Could not be determined 28a. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

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28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29e. Certifier (Check only one)

4 ☐ Homicida

\(\mathbb{K}\) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es stated.
2 \(\mathbb{Medical Examiner}\): On the basis of exeminetion end/or investigation, in my opinion, death occurred et tha time, data end place, and due to the cause(s) and menner stated.

29b. Signatura and titla of certifier

29c. Licansa number 5047D

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29d. Date signed (Month, Day, Year) 2000 31

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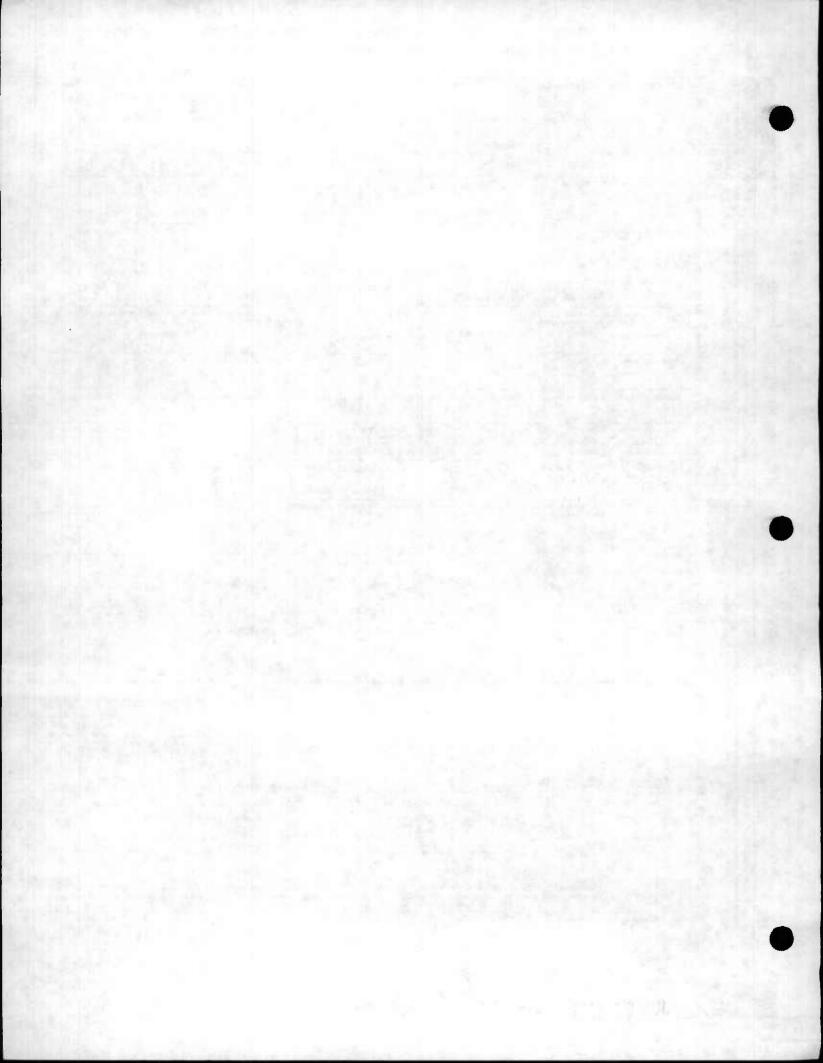
30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) S. ATLURI M.D., 1319 Light Struf 31. Data filed (Month, Day, Year)

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32. Registrar's Signatura

Baltimore

Registrar



DHMH 16 Rev 6/95

Registrar

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Year **Physician** ththous 29,2000 MAY 06:57 AM /Medical 4a Fecility Neme (ff not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. If Under 1 Yeer Months Days 9. Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 10 M 2□ F 195-07-2932 Usual Residence of Deceden Maryland Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No Funeral Director 288-1 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 23a or 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. or items 11. Marital Stetus permit. Pages 1 and 2 should be find within 72 hours after. Department of Health and Mernal Hygiens. Important: If term 27 is marked other than. 1 Ves 2 No If Yes, Give Yaar or Dates: WW∏ 1 Never Married 25 Married 1 Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) driver 1-eamster 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be 19a. Informati's Name/Relettonship (Type, Print) JOSEPHIKE 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 269. Place of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, State 20e. Method of Disposition Date June 1 1 Buriel 2 Cremetion 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 2000 22. Name and Address of Facility 21. Signature of Fureral Service License 8800 Md 21234 Approximete Interval Between Onset and Death 23d. Perfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such) as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Ph sician PULMONARY EDEMA /Medical Immediate Ceuse (Final DAYS disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner MYOCARDIAL INFARCTION 1 WEEK The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last the bunal-tran and Due to (or es a consequença of): Physician/Medical Due to (or es a consequence of): use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown þ 24e. Wes an eutopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of deeth? Medicai Certification: To Be Completed 2 0 No 2 No 1 Tyes 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 1 Neturel 2 Accident 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation s efter death. I Director: After death. I by the fur 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral DI 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and placa, and due to the cause(s) end manner stated. 29a. Cartifier completely (Check only one) 29b. Signature end-title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

Box 68760.

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Division of Vital Records,

31. Date filed (Month, Dey, Year) 2000

TIMOTHY LOW,

Registrer's Signeture

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30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

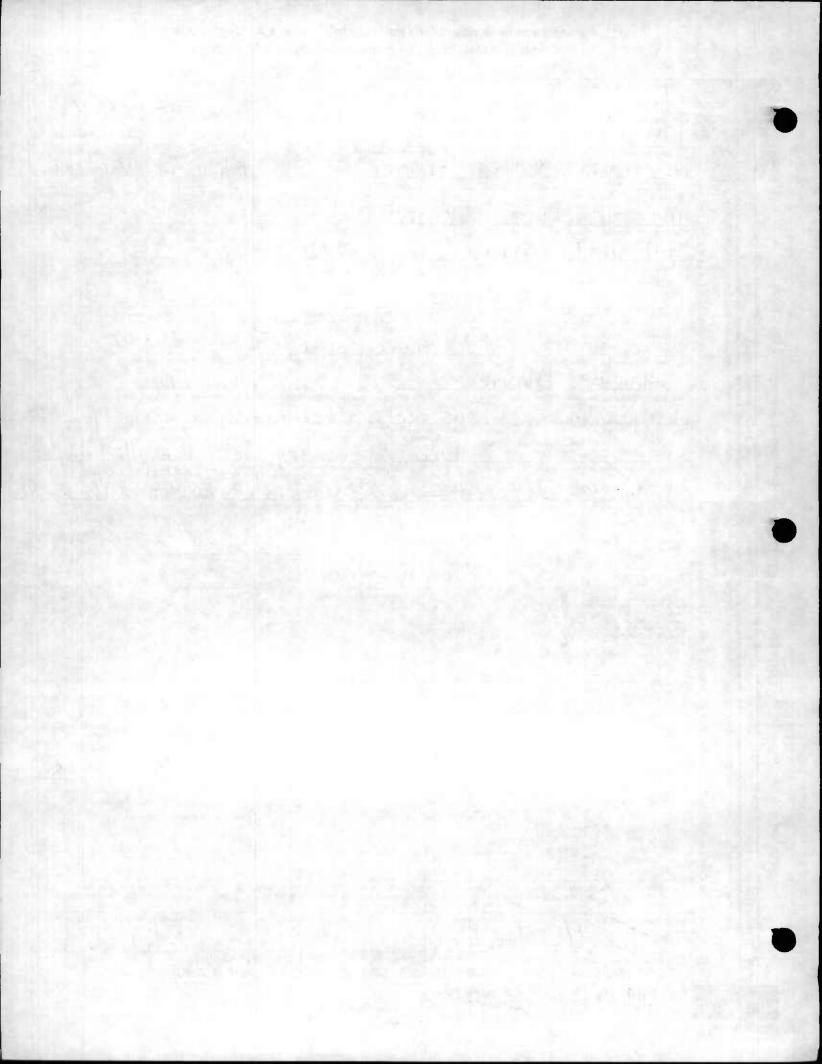
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DHMH 16 Rev 6/95

Registrar



Registrar **DHMH 16 Rev 6/95**

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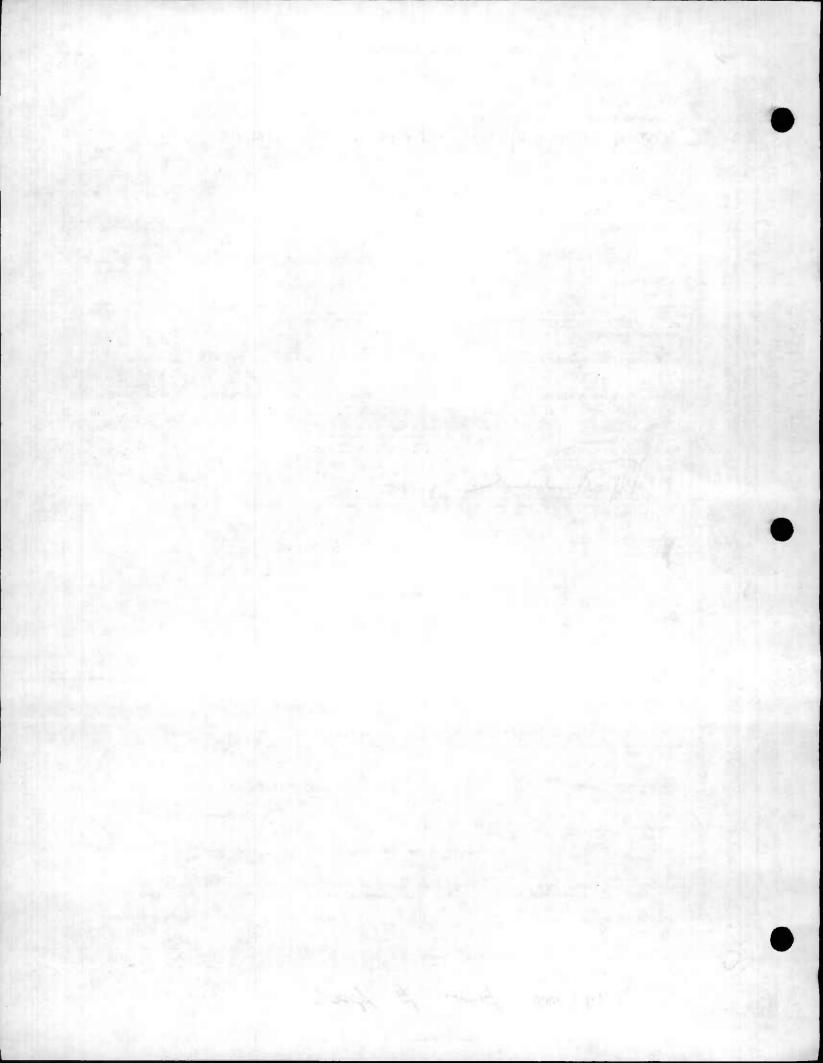
31. Date filed (Month, Day, Year)
JUN 0 1 2000

Balhmore MD 21230

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KNESAINM Death Medical Conter 611 south charles smeet

32. Registrar's Signature



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7494 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Mariah Angel Mosley May 24, 2000 4:49 AM 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Columbia Howard County General Hospital Months Days 8. Date of Birth (Month, Day, Year) May 14, 2000 Birthplace (State or Foreign Country) Maryland 5. Social Security Number 1 N/4 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Months Hours 10 M 20 F 0 Yrs. Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes Ž ☐ No Maryland Howard West Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21794 U.S.A. 3173 Foxvalley Drive 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status 14. Rece - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Not Self Supporting Elementery/Secondery (0-12) College (1-4or 5+) Dependent 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Tammy Ann Beard David Mosley 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3173 Foxvalley Drive West Friendship, Maryland 21794 Mr. David Mosley 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 05/27/00 Clarksville, Maryland Columbia Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MOIII3 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to 24a. Wes an eutopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

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Funeral

Director

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Director

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permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryle Department of Heelth and Mantel Hyglena. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumstic event, the Madical Examiner must be notified at page.

Baltimore, Maryland 21215-0020

2 Be

The law requires that the death certificets be executed

P.O. Box 68760,

Records,

Division of Vital

Physician/Medical Examiner attending physicien end for use as the burlel-transit signed by the cate hes been sign, pege 2 should b Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Medical Certification: To

certificate

26. Place of Deeth (Check only one)

2000

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of

27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Naturel 5 Pending investigation 1 Yes 2 No 2 Accident

6 Could not be determined 3 Suicide Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one) 29b. Signeture and this of certified

25. Was case referred to medical

29e. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

D47620

Neme and address of person who completed cause of death (Item 23a) (Type, Print) Bharti Razdan, M.D. 5755 Cedar Lane Columbia, Maryland 21044

State Registrar 31. Date filed (Month Pay Year) 2000

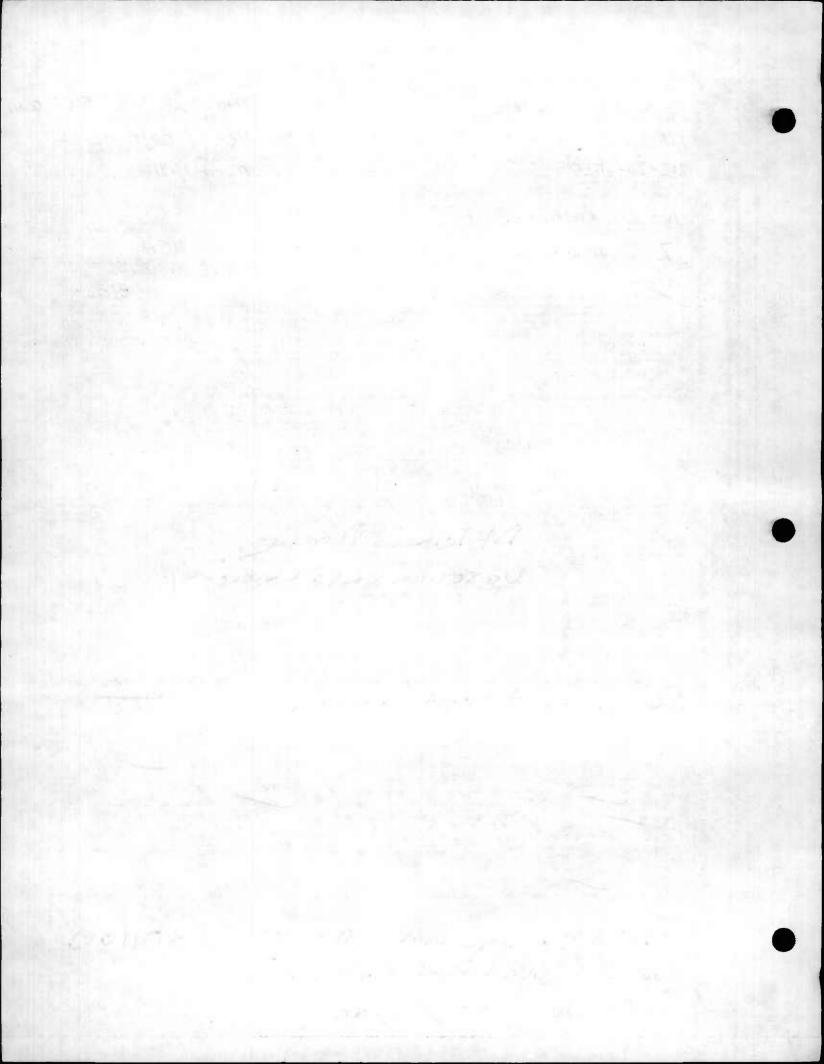
JUN B 1 2000 Bearing to Agree

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

		State of Maryland	Department of I Certificate of		al Hygiene () (17495				
S 1 -1-1-	1. Decedent's Neme (First, Middle, Last)		2. Date of Death 3. Time of Death						
Physician /Medical	Emily L	ans		May 28, 2000 5:00						
Examiner	4e Facility Name (If not institution, give	street and number)		4b. City, Town, or Location						
	Pikesville Nurs	ing and Keha	bilitation	Pikesville	Balt	i more				
uneral	5. Social Security Number 6. Se	7. Age (In yrs. last		If Under 24 Hrs. 8. De Hours Min.		9. Birthplace (State or Foreign Country)				
ector	212-20-6525	IM 2014 90	Yrs.		arch 1, 1910	/D				
	Usual Residence of Decedent	To a m				104				
	10a. Stete 10b. County		own or Location			10d. Inside City Limits				
용	Md. Baltin	more PIKE	SVILLE			1 ☐ Yes XX No				
Director	10e. Street and Number		10f. Zip Code		10g. Citizen of Wh	at Country?				
	7 Sudbrook	Lane	212	-08	USA					
Funeral	11. Maritel Stetus	12. Wes Decedent Ever in U,S. Armed Forces?	13. Wes Decedent of I If Yes, specify Cub		American Indien, White, etc.					
	1 Never Merried 2 Merried	1 ☐ Yes 2XX\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1 Yes 2 □√√√							
d Dy	3 ☑ Widowed 4 □ Divorced	Yeer or Detes:	M		Ороспу.	Black				
ete.	15. Decedent's Edu (Specify only highest grad	cation 1 e completed)	 Decedent's Usuel Occup (Give kind of work done 	during most of working	16b. Kind of Bus	ness/Industry				
Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	Tife. DO NOT use retire	(d)	DAT MTMODI	OTEN COLLOCE				
S	12TH GRADE		USTODIAN		BALTIMORE CITY SCHOOL					
Be	17. Father's Neme (First, Middle, Last) CHARLES BREESE				t, Middle, Meiden Sumeme,					
2	CIARLES BREESE			EMMA MILLE	IK .					
	19e. Informent's Neme/Reletionship (T)		19b. Mailing Address (Street							
	ANDREA COGER	DAUGHTER 4	1720 BONNIE B	RAE ROAD BAL	TIMORE, MD.	21208				
	20e. Method of Disposition 1 □XB rial 2 □ Cremetion 3 □F	COM	e of Disposition (Name of etery, cremetory or other pla	Dat	e 20c. Location - C	ity or Town, Stele				
	4 Donetion 5 Other (Specify)		ARDS MEMORIAL	PARK JUNE	1 EASTON,	MD.				
	21. Signeture of Funerel Service Licens	88.	22. Name and Addre	ess of Facility אין דיון דון	R FUNERAL HO	MES INC				
	16 + 7	Van V	2501 GWYNN		BALTIMORE,					
	23a Part Fotor the disease or comple	ications the caused the death. [Approximate				
	23a. Perf1. Enter the disease, or compleshock, or heert feiture. List only or	ne cause of each line.	or not onto the mode of dy.	rig, occir as outomo or resp	motory entost,	Interval Between Onset end Death				
	Immediate Cause (Finel	notal ?	M = i.							
	disease or condition resulting in deeth)	H 15 HC	MOS AVI	score						
70		Due to (or as a consequence of):								
Examiner		CORSEC	Ica Tuil	3 £ 6161	62001.					
×a	Sequentially list conditions, if any, leading to immediate	Due to (or as e consequence of):								
	Cause (Disease or injury									
dicai	that initieted events resulting in death) Last	Due to (or as	a consequence of):							
lan										
Physician/M	Part It. Other significant conditions con	tributing to death but not resultin	ven in Part I. 2	23b. Did tobacco use contribute to the cause of death?						
	Raginger	tage /	nem	1 Ca	1 Yes 2 No 3 Probably 4 Unknown					
by	1710.1100		1000							
Completed				2	4a. Wes en autopsy performed?	24b. Were eutopsy findings eveileble prior to				
ple						of death?				
PO					1□ Yes 2⊟No	1 □ Yes 2 □ No				
0	25. Wes case referred to medical			26. Place of Deeth (Che	ck only one)					
OB	examiner?	lospitel:	Outpatient 3 DOA Ot	har i	☐ Residence 8 ☐ Other	(Specify)				
n: T	27. Manner of Death	28a. Date of Injury 28	b. Time of 28c. Inju		Pescribe how injury occurred					
atio	1 ☐ Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		rk? Yes 2 □ No						
fice	3 ☐ Suicide 6 ☐ Could not be	28e. Plece of Injury - At home	, ferm, street, factory, office	28f. Lo	ocation (Street and Number	or Rurel Route Number,				
Certification:	4 LI Homicide	4 Homicide determined building, etc. (Specify)								
2	29a, Certifier 1 Certifying Phys	irian: To the best of my knowler	ing death occurred at the ti	me date and place and di	us to the cause(s) and man	or on stated				
edicai	(Check only one) 2 Medical Examin	ician: To the best of my knowled ner: On the basis of examination and menner steted.	and/or investigation, in my o	opinion, deeth occurred et t	he time, dete end plece, en	d due to the ceuse(s)				
Me	29b. Signeture and title of certilier	and morkier stelet.	29c, Licens	se number	29d Date sinned	(Month, Day, Year)				
	1 1 1 1 1 1	(200. 2001	V > ->	C Sale signed	29d. Date signed (Month, Dey, Year)				
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	30. Neme and address of person who co	1 1 1	a) (Type, Print)	27/1						
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ate	31. Dete liled (Month, Day, Year)	32. Registrar's Signeture	, ,							
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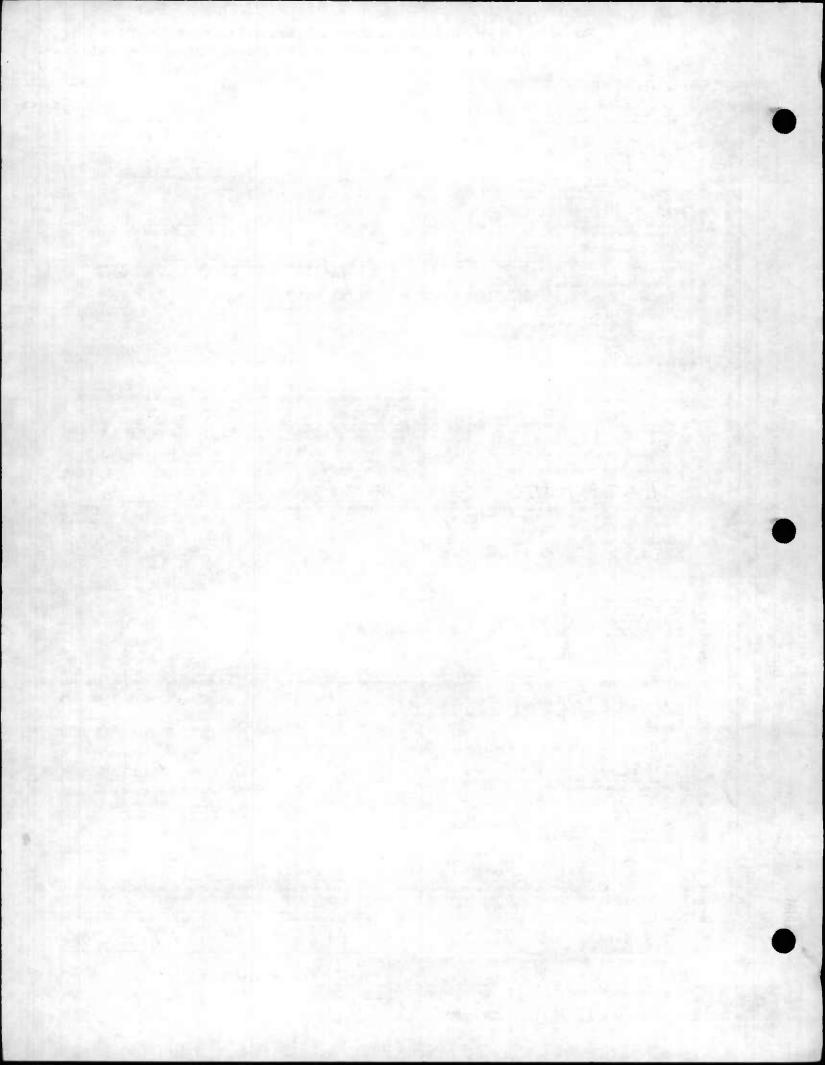
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31	T. U. S	1. Decedent's Nen	ne (First, Middle, Li	nst)		750		100	6,60 0	2. Date of De Month	ath Day	Year	3. Time of Death	
The same	Physician /Medical	RUTH ROLAND MATTHEWS								MAY	-	2000	1430HRS	
	Examiner	0	(If not institution, gi						4b. City, Town, or					
			FNES	HOSPI				1 Vaar	DATE	MORE				
	Funeral	5. Sociel Security ! 218–10–9		Sex 1 M 2 Syfx	7. Age (In yrs. 84	lest birthd Yrs	Months	Days		(Month, Da	th ly, Year)	Cour	plece (Stete or Foreign ntry)	
-	Director	Usual Residence		M	04			+		MARCH	1, 1916	MD.		
	the Merylenc 28-1 show notified at	10a. Stata MD.	10b. County BAL	TIMORE	10c. Ci	ty, Town o		WOOL	OLAWN			1	1 Yes 2 XX	
	urs effer death with lift, or items 23a or Laminst must be by Funeral DI	10e. Street and Number 2101 MEADOWVIEW DRIVE					10f. Zip	Code	21207		10g. Citizen of What Country? USA			
020		11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in Armed Forcas? 1 Yes 2 No If Yes, Give Year or Dates:			rcas?	J,S. 1	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puarto Rican, etc.) □ Yas 2				No- 14. Raca - American Indian, Black, White, etc. Specify: BLACK			
15-0	uld be filed within 72 hours Mentel Hygiene. Inted other then "neturel", site event, me wantel En	15. Decedent's Education (Specify only highest grade completed)				18a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)				rking	ing 16b. Kind of Business/Industry			
212	then.	Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE			-4or 5+)	CAFETERIA DIETIAN				BALTIMORE PUBLI			URLIC SCHOO	
p	other of Hyg		17. Father's Name (First, Middle, Last)							ne (First, Middle, Meiden Sumeme)			Obblic Baloo	
ylar	should be nd Mentel merked o urmetic ev	ANDREW JAMES FINNEY				EDNA HOI				LLEY				
, Maryland 21215-0020	iges 1 and 2 should be filed within to the feel and Mentel hyghere. It fem 27 is marked other than or other traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic events the Mentel trauma	19a. Informant's Neme/Reletionship (Type, Print) BRENDA B. STREETS DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2101 MEADOWVIEW DRIVE WOODLAWN, MD. 212												
Baltimore,	permit. Peges 1: Department of He important: If item eny injury or oth		position Cremation 3 [5 Other (Speci		Stale	cametery,	sposition (Nan cremetory or o	ther pla	AL CEMETE	MAY 26	20c. Location			
alti	Departm Departm Importa eny Inju	21. Signature of F	uneral Service Lice	nsee			22. Name an	_			BALTIMOR JNERAL H			
0	88 = 58	Herbe	it & nu	itter			2501 GV	NYNN	S FALLS					
	Physician	23a. Part1. Enter shock, or her	the disaase, or con ert failure. List only	nplications that co one cause on e	ausad lhe deal ech line.	Ih. Do not	enter the mod	a of dyi	ng, such as cardia	c or raspiratory a	rrast,	1	Approximate Interval Between Onset and Death	
	/Medical Examiner	Immediate Cause disease or condition resulting in death)	no	a		P51	-						5DAYS	
4	ةِ السِّيع				Dog to (c	or as a con	sequenca of):					1		
FEW 3760,	use be executed hysician and he burial-transit	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease of	enditions, mmediate erlying	b	Due to (d	or as a con	sequenca ot):				. 72%	1		
	Z EC =	That initiated events Due to (or as a consequence of):												
H.	death se ette ed for	Part II. Other signi	ficant conditions	contributing to de	ath but not res	sulting in th	e underlying c	ause gi	ven in Part I.	23b. Did	tobacco uas co	ntributa t	o the cause of death?	
MA.	s that the pred by the detach	HYPOCALCEMIA						10	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown					
Records,	The lew requires that the death certifice also been signed by the attending phyage 2 should be detached for use as the completed by Physician/Med	METABOLIC ACIDOSIS						24a. Was	a. Was an autopsy performed?		are autopsy findings allable prior to impletion of cause death?			
<u>a</u>	certificate hes rector, page 2 Be Comp	CHRO	NIC	REA	ML	FA	ILUR	E		10	Yes 27 No	11	☐ Yes 2☐ No	
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1 5	Attending Physician: r deeth. ector: After this certific by the funeral director, lification: To Be (1 2 Naturel 2 Accident	5 Pending investigation		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No									
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E E	To the Hospital or Attending Physician: The lew requires that the death certifice within 24 hours afterdeeth. within 24 hours afterdeeth. to the Funerial Director: After this certificate hes been signed by the extending pt completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Med	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the care (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the care and manner stated.												
AAME	Within To the Domp	29b. Signatura and	I title of certifier		29c. License number				29d. Date signed (Month, Dey, Year)			Dey, Year)		
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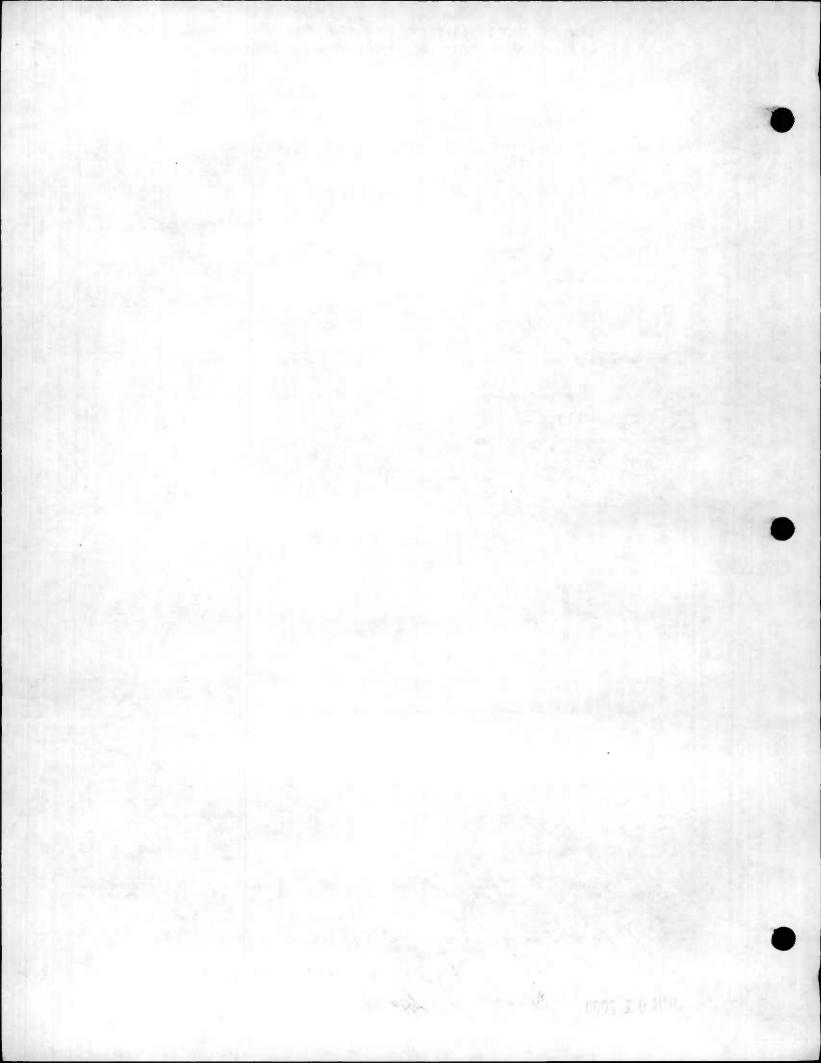
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7497 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month **Physician** Patricia Ann Monaghan 31, May 2000 9:43 AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Gilchrist Center Towson Baltimore 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 28, 19 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 ¥F 209-18-0560 Yrs. 74 1925 Director New Jersey Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f ahov must be notified at 1 ☐ Yes 2 TX No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 1703 Seminole Court USA deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours efter 1⊠ Never Merried 2 Married 21215-0020 6 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Elementery/Secondary (0-12) College (1-4or 5+) Teacher 5+ Education other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Peges 1 and 2 should be fill ment of Heelth and Mental H lant; If item 27 is marked off Be Helen Zell Francis M. Monaghan 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Getzendanner/Friend 336 W. Kenwood Avenue Catonsville, MD 21228 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Peges 1 Department of H Important: If its any injury or ot pace. 1 ☐ Burial 2 XCremetion 3 ☐ Removet from State Metro Crematory, Inc. 6/1/00 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Edward A. Fregorchik Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervat Between Onset end Death **Physician** Immediate Cause (Finet disease or condition resulting in deeth) /Medical concer 6 months Examiner Due to (or es e consequence of): Examiner The lew requires that the deeth certificate be executed for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Records, P.O. Box 68760. attending physicien Physician/Medical Due to (or es e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed b þ Completed 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? peed completion of cause of death? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Attending Physician; director Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To After this filled in by the funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Neturel deeth. 1 Yes 2 No 2 Accident after deeth Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as steled.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) 29a. Certifier and menner sta 29b. Signature and 196 of pertilier 29c. License number 29d. Dete signed (Month, Day, Year) 2000 our cause of death (Item 23a) (Type, Print) N. Charles St. Balto. and 20208 124 6701 5m(31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

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2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 498 Certificate of Death AMEND#1 PER MD. G784 5-6-2000 JAB 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death MATNOR Day Month Vear **Physician** ANNIE J. MANIOR 30 AC MAY 21 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City General Baltimore Maryland HOSpital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) NOV . 2 , 1902 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 10 M 2QF Montha 97 219-07-0268 NORTH CAROLINA Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits If Is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1324 N. DALLAS STREET 21213 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married Maryland 21215-0020 AFRO -AMERICAN 1 ☐ Yea 2 ☐ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6ТН CHURCH HOME HOSP. LABORER IN LAUNDRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be le marked LEVI PERRY CLARA WHITE 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addresa (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Nem 27 DORIS M. CLIFTON / 2116 EAGLE ST. BALTO, MD. niece altimore, 20b. Piece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MT.CALVARY CEM. JUNE 6,2000 BALTO, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat Funeral Service Licenses 22. Neme and Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME adene 1412 E. PRESTON STREET BALTO, MD. 21213 23a. Pert1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final · ASPIRATION PREDMONIA disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner SEPSIS The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760, . INFECTION AT GTUBE Physician/Medical the Due to (or es e consequence of) for usa signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Waa an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata of Vitai Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes No this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar Division or Attending 5 Pending investigation after deeth.

I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier complately (Check only one) within 2 945 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05, 27, 00 hus

State Registrar

EZUMI

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

MAINOR, ANNIE

CO MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

MD

32. Registraris Signeture

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death , 90 1. Decedent's Neme (First, Middle Last) 2 Date of Death 3. Time of Death Dey **Physician** MAY 20**ඊ** 30 7:45AM MARKOWITZ EVA /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE PIKESVILLE NURSING HOME PIKESVILLE If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. APRIL 4 5. Sociel Security Number Birthplace (Stete or Foreign RUSSIA 6 Sax 7. Age (In yrs. last birthday) **Funeral** Y9908 Months 1□ M 2√ F Yrs. 240-01-3275 Director Usual Residence of Decedent 10a. Stete MD. 10b. County N/A 10c. City, Town or Location 10d. Inside City Limits BALTIMORE Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3113 BANCROFT ROAD APT. E. 21215 USA 238 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Meritel Status Black, White, etc. permit. Plages 1 and 2 should be filed within 72 hours after Oppartment of Health and Mental Hygiene. important: if New 37 is marked other than "natural", or ther any finjury or other traumatic event, the MacEnsi E. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) OWNER GROCERY STORE 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be PHILIP KAPLAN CHASSIE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) CARL MARKOWITZ/SON 8 FARMHOUSE COURT BALTIMORE, MD. 21208 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete cemetery, cremetory or other plece)
TIFERETH ISRAEL ANSHE 1 Burial 2 Cremetion 3 Removel from State
4 Donation 5 Other (Specify) 5/31/00 ROSEDALE, MD. SFARD 22. Name and Address of Fecility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 ations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, cause on each line. Approximete Intervel Between Onset and Death art I. Enter the disease, or hock, or heart failure. List **Physician** Immediate Cause (Final disease or condition resulting in deeth) Congestue heart Failure /Medical Y-eare Examiner Due to (or es e consequence of): Physician/Medical Examiner HASWES The law requires that the deeth certificate be executed anding physician and use as the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760, Due to (or es a consequence of) P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? De ditte nellets 1 Yes 2 No 3 Probably 4 Unknown Records. 50 P 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en autopsy performed? 1 Yes 20 No 1 Yes 2 No certificate Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier (Check only one)

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) JUN 0 1 2000

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature end title of certifier

S.H. MACINOW 32. Registrar's Signeture

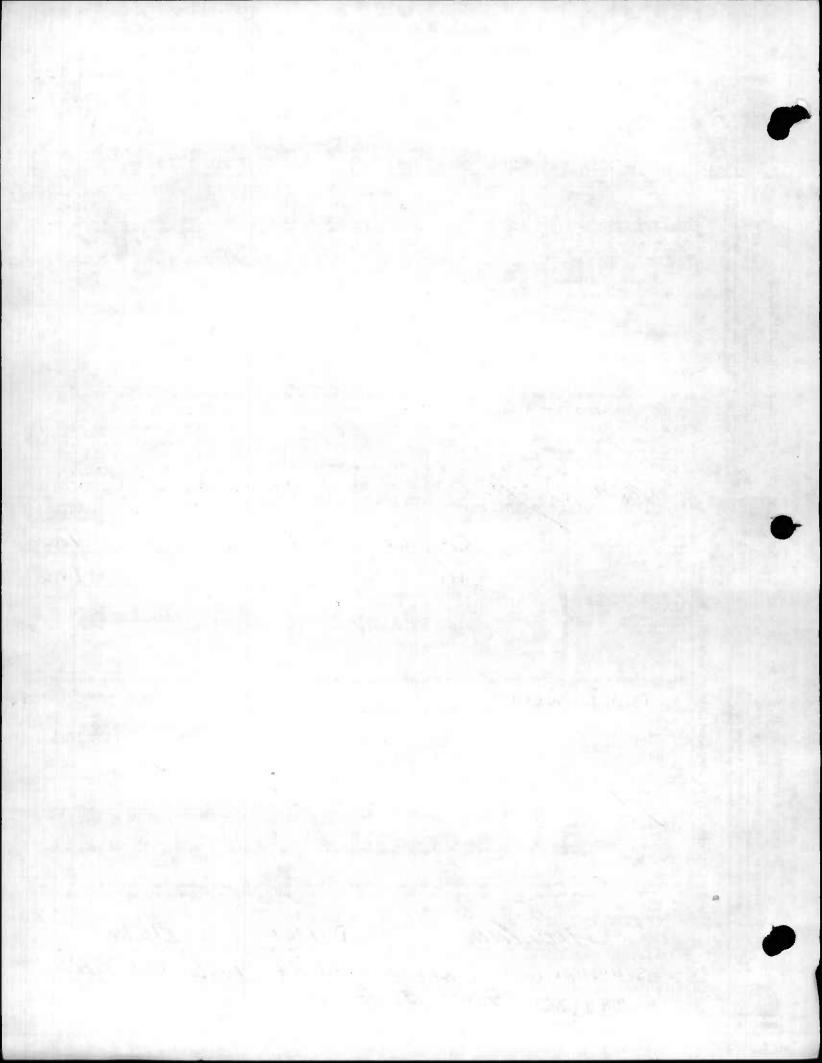
3635 Old Court Ad BAHO. Md 21208

29c. License number

D04701

29d. Date signed (Month, Day, Year)

5/30/00



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 28, 2000 6:30 pm May Novak Robert /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7903 Eastdale Rd Eastwood H Under 1 Year | H Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Mar. 23, 1942 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 2 F 58 Director Md. <u>214-38-1048</u> Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Md Baltimore Eastwood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 USA 7903 Eastdale Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 25€No Specify: Specity: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Sity 10 yrs Police Officer permit. Peges 1 and 2 should be filled Department of Health and Mentel Hyg Important: If Nem 27 Ia marked other any Injury or other traumatic event, 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Ukawski Nicholas Novak 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7903 Eastdale Rd. Eastwood, Md. 21224 wife Louise Novak 20b. Placa of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition May 31 cametery, crematory or other placa) 1 ■Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus 2000 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Md: 21. Signature of Fungal Con 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md 21222 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ENT CANCER 5 MON141 Examiner Due to (or as a consequenca of): Examiner certificate be executed physicien and s the burief-trens Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca ot): P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 88 USB (for ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ®Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records. à been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed hes 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No cartificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5 Residenca 6□ Other (Specify) 1 ☐ Yes 2 PNo P After this funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred **DR**Natural 5 Pending investigation I Director: After death. 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicida 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 ☐ Homleide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 019714 maan 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) AL BALTIMOR Punzell J48VAL 4940 BASTENS

State Registrar

*(qar)

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32. Registrar's Signeture